MEDICARE AND MEDICAID'S 25TH ANNIVERSARY—MUCH PROMISED, ACCOMPLISHED, AND LEFT UNFINISHED

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JULY 30, 1990

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RICHARD A. VELOZ, M.P.H., J.D., *Staff Director*
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MEDICARE AND MEDICAID'S 25TH ANNIVERSARY—MUCH PROMISED, ACCOMPLISHED, AND LEFT UNFINISHED

MONDAY, JULY 30, 1990

U.S.HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 1:08 p.m., in room 2175, Rayburn House Office Building, Honorable Edward R. Roybal (chairman of the committee), presiding.

Members present: Representatives Roybal Downey, Oakar, Borski, Clarke, Kennedy, Pallone, Bentley, Meyers, Morella, and James.

Staff present: Richard A. Veloz, Staff Director; Gary Christopherson, Director of Health Legislation; Yvonne Santa Anna, Professional Staff; Valerie Batza, Executive Assistant; Carolyn Grifffith, Staff Assistant; Diana Jones, Staff Assistant; and Seth Masket, Intern.

OPENING STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

The CHAIRMAN. Ladies and gentlemen, the purpose of this hearing and the report that I'm releasing today will help examine the promise of Medicare and Medicaid when first enacted, the protection provided over the past 25 years, the gaps remaining with respect to Americans without health insurance, and without long-term care protection.

It also examines the next step towards insuring health and long-term care protection for all Americans of all ages. I believe that there is much to be proud of. Ever since Medicare and Medicaid began, millions of Americans who are poor, are elderly, or have major disabilities, have received care funded by these two programs. Much to their credit, working Americans of all ages have supported these programs on a daily basis.

But unfortunately there is another side to this success story. For all their accomplishments, the Medicare and Medicaid programs have problems. Since 1965, long-term care protection has emerged as a weak spot in our system. Today, there are 37 million Americans that have no health insurance whatsoever. There are over 200 million Americans that are uninsured against long-term care costs and the only large scale program protecting younger and older Americans is Medicaid.

Unfortunately, a person's price of admission to Medicaid and its long-term care protection is either being poor to start with or

spending down to poverty. Over the past 25 years, much has been promised and much has been accomplished with respect to Medicare and Medicaid, but much more has to be done. A final chapter on health and long-term care in America is far from being written. The task falls to the Administration and to the Congress of the United States, which are the public custodians of Medicare and Medicaid.

We must complete this agenda by ensuring that no American lacks final access to needed health and long-term care and that no American need fear financial and emotional ruin from costly and disabling illnesses. A well-planned program, a national program, is a must for this Nation. We will examine that possibility.

The men and women that will be testifying this afternoon will be telling us about Medicare, its successes and its problems. We sincerely hope that the time will come when this committee will make actual recommendations, for the report that we're releasing today does not make recommendations. This document has been printed for informational purposes only, and I repeat that it does not represent either findings or recommendations adopted by this committee.

Those recommendations will be made when we finalize our search for the truth for what actually is the problem. And then this committee, together with the House of Representatives and the Senate of the United States, will make additional recommendations.

It is indeed a pleasure to have this morning a man who has been not only interested but instrumental in drafting a recommendation that is, I think, establishing a historical beginning. That is Senator Rockefeller, who joins us today in his role as Chairman of the Bipartisan Commission on Comprehensive Health Care. As you know, that is the old Pepper Commission.

I remember that Senator Pepper sat where I sit now. I remember his effectiveness, his dedication to this program, and the things that he has done. May I say that I don't believe that there will ever be a man that will equal that accomplishment, for in my opinion, there was only one Senator Pepper.

But then there is also one Senator Rockefeller, a man who has already shown his leadership in this field. It gives me a great deal of pleasure to present to him the other members of the committee, asking them to make a brief statement, and then proceed with his statement.

[The prepared statement and background paper submitted by Chairman Roybal follows:]

PREPARED STATEMENT OF CHAIRMAN EDWARD R. ROYBAL

In 1985, we labeled the 20th anniversary as a "bittersweet" occasion because the history of Medicare and Medicaid is replete with many accomplishments, many problems and many gaps. On the occasion of the 25th anniversary of these two key health protection programs, the label still applies and the feeling is the same. While there has been some progress, much of the promise and hope enshrining these two programs remains unfulfilled.

The purpose of today's hearing and the report I am releasing is to help examine the promise of Medicare and Medicaid when first enacted, the protection provided over the past 25 years, the gaps remaining with respect to Americans without health insurance and without long term care protection, and the next steps toward ensuring health and long term care protection for Americans of all ages.

There is much of which to be proud with respect to Medicare and Medicaid. Each year since Medicare and Medicaid began, millions of Americans who are poor, are elderly or have major disabilities have received care funded by these two programs. Medicare has relieved a large portion of the financial burden of acute care costs for its beneficiaries. Medicaid has taken away the financial burden of acute and long term nursing home costs for those who became Medicaid beneficiaries. This is no small accomplishment during a time when health care costs have skyrocketed and America has seen its elderly population grow significantly and its poor population remain substantial. Much to their credit, Americans of all ages have continued to support these programs not only with their words but with their tax and premium dollars.

But there is another side to this success story. For all their accomplishments, the Medicare and Medicaid programs have problems. Rising health care costs have put enormous pressure on these programs, the American taxpayer, and the beneficiaries. Even with more than a decade dedicated to cost containment, effective cost containment is still out of our reach. As just one example, our own study has shown that today's elderly are spending nearly one-fifth of their income on health care, one and one-half times higher than the level in 1977.

Over the past 25 years, quality assurance efforts have made major strides forward but have still to fully address health and long term care quality in many settings, including ambulatory care and home care. Further, much of today's quality assurance is tied to Medicare and, to a lesser extent, Medicaid leaving the privately insured and the uninsured without adequate protection. Also, quality assurance has acquired a new rationale in a period of cost containment. Much more than in the past, quality assurance can become a means for measuring the impact of cost containment policies and documenting when and where cost containment may do or be doing damage.

For all the people who have been protected by these programs, there are many more who remain unprotected. Today, 31-37 million Americans are uninsured for health care at any point in time. Nearly twice that number experience being uninsured in a two year period. Many millions more remain at risk as their insurance is woefully inadequate to meet the challenges and the costs of modern day health care.

Since 1965, long term care protection has emerged as a weak spot in our system. Today, over 200 million Americans are uninsured against long term care costs and the only large scale program protecting younger and older Americans is Medicaid. Unfortunately, a person's price of admission to Medicaid and its long term care protection is either being poor or spending down into poverty.

Turning to the future, it is again likely to be a time of great turmoil for health and long term care in America. Unless we enact large scale reform, health and long term care costs are likely to continue to outstrip our ability to pay for them. Without large scale reform, the number of Americans without health insurance will remain over 30 million and the number of Americans without long term care insurance protection will remain over 200 million. None of these "status quo" situations is tolerable.

Today, we are fortunate to have many reform proposals on the table from a wide spectrum of organizations, coalitions and members of Congress. Many of the proposals would shore up one or more of the weak spots and gaps in Medicare, Medicaid or private insurance protection. Some proposals focus more on private sector solutions while others focus more on public sector strategies.

More and more proposals are being designed to bring about comprehensive health and long term care reform. Some, such as my own USHealth Act (H.R. 2980), lean toward a federally-based, nationwide program built upon Medicare and covering health and long term care. Some comprehensive proposals, like the Pepper Commission recommendations, use employer-mandated health insurance, Medicare and an improved Medicaid-type program to ensure health and long term care protection. In addition, more and more interest is also being shown in using part or all of Canada's system as a basis for comprehensive reform. What is promising is that comprehensive reform continues to pick up supporters from a broad spectrum of the American public and that there is a substantial openness to different approaches, as long as they accomplish the goal of ensuring protection for all Americans.

Over the past 25 years, much has been promised and much has been accomplished with respect to Medicare and Medicaid. However, the final chapter on health and long term care reform in America is far from having been written as much is left unfinished. The task now falls to the Administration and Congress, the public custodians of Medicare and Medicaid, to complete the agenda and to ensure that no American lacks financial access to needed health and long term care care and that no American need fear financial and emotional ruin from costly and disabling illnesses.

NEWS
Select Committee on Aging
U.S. House of Representatives

EDWARD R. ROYBAL, Chairman
300 New Jersey Ave. S.E., Room 712
Washington, D.C. 20515
202/226-3375

BACKGROUND

CONTACT: Gary Christopherson, Yvonne Santa Anna,
Tony Hausner, Carolyn Griffith; 202-226-3375

MEDICARE AND MEDICAID'S 25TH ANNIVERSARY —
MUCH PROMISED, ACCOMPLISHED, AND LEFT UNFINISHED

HEARING OF THE HOUSE SELECT COMMITTEE ON AGING
EDWARD R. ROYBAL, CHAIRMAN

1:00 p.m., Monday, July 30, 1990

2175 Rayburn House Office Building
Washington, D.C.

PURPOSE. The hearing will examine the promise of Medicare and Medicaid when first enacted, the protection provided over the past 25 years, the gaps remaining with respect to Americans without health insurance and without long term care protection, and the next steps toward ensuring health and long term care protection for Americans of all ages.

WITNESSES.

* John D. Rockefeller, Chairman of the U.S. Bipartisan Commission on Comprehensive Health Care and U.S. Senator from the State of West Virginia.

Witness Panel.

* Gail Wilensky, Ph.D., Administrator, Health Care Financing Administration, U.S. Department of Health and Human Services, Washington, D.C.
* Mary Bowden, Grandmother whose multigenerational family faces pressures resulting from lack of health insurance and need for long term care, Maryland. Accompanied by Sharon McKinley, Administrative Specialist, Prince Georges County Department of Social Services.
* Burt Lancaster, Actor and Representative of the Screen Actors Guild, Hollywood, CA.
* Arthur Flemming, Former Secretary, U.S. Department of Health, Education and Welfare, Washington, D.C.

BACKGROUND INFORMATION:

Today the Chairman is releasing a report, "Medicare and Medicaid's 25th Anniversary -- Much Promised, Accomplished, and Left Unfinished," examining the history and future of these two programs. As it indicates, much has been promised and much has been accomplished with respect to Medicare and Medicaid, but the final chapter on health and long term care in America is far from having been written as much of the work is left unfinished.

THE PROMISE. Twenty-five years ago on July 30, 1965, President Johnson signed into law the Medicare and Medicaid programs as Titles XVIII and XIX respectively of the Social Security Act. As enacted, the Medicare program was designed as a national, federally administered program with uniform eligibility and benefits tied to the Social Security program. Part A, the hospital insurance program, provides protection for mostly inpatient acute care; while part B, the supplementary medical insurance fund, covers doctor visits and other ambulatory services. The Medicaid program is a Federal grant program which is administered by the States and is targeted toward lower income individuals and families. It covers a broad range of hospital, nursing facility and other medical services.

When these programs were enacted, many persons expected that Medicare and Medicaid would ensure full coverage of all health care services for the elderly, disabled, and poor. While these programs have gone through many changes in their 25 year history, and much has been accomplished during this time period, the report indicates that there remain many gaps and weaknesses.

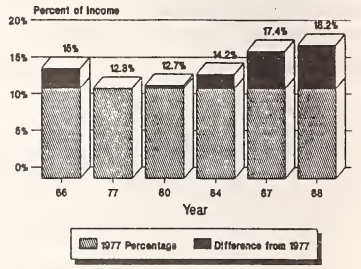
ACCOMPLISHMENTS. The Medicare and Medicaid programs have made many important contributions to the health care needs of the elderly, disabled, and the poor. The following statistics give some indication of this contribution. In 1989, society contributed over $120 billion to parts A and B of the Medicare program, and $54 billion to the Medicaid program. These programs have primarily been funded by the taxpayer though Social Security and general income taxes, and by the elderly through these taxes and through premiums.

Over the years, these programs have served many beneficiaries, and, therefore, have provided them access to health care and protected them from much of the burden of considerable health care costs. In 1989, Medicare served 32.5 million beneficiaries and Medicaid served 23.5 million beneficiaries. An examination of a few key services gives an even better perspective on these programs' contributions. In 1987, Medicare provided nursing home care to 300,000 persons, and physician and other medical services to 23 million persons. For Medicaid in 1988, the number of beneficiaries who received skilled and intermediate nursing home care was 1.59 million and the number who received physician services was 15.26 million.

THE UNFINISHED AGENDA — GAPS AND WEAKNESSES IN MEDICARE AND MEDICAID. Despite the many accomplishments of these programs, there still remain many gaps and weaknesses that need to be resolved.

Health care costs have been rising at rates more rapid than the cost of living for at least the past two decades. This has created problems for the entire health care field, for Medicare and Medicaid, and for the elderly, the disabled, and the poor. For instance, between 1983 and 1989 medical care prices rose at twice the rate of inflation. For the elderly and others with lower, relatively fixed incomes, this has particular consequences. The elderly's out-of-pocket costs increased from 12.3 per cent of their income in 1977 to 18.2 per cent in 1988 (see Figure).

Elderly Out-of-Pocket Health Costs
As A Percent Of Elderly Mean Income



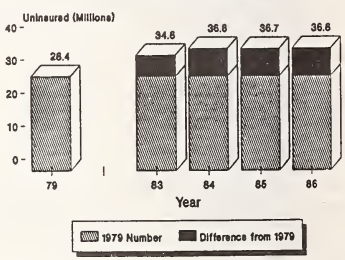
Source: House Committee on Aging, 1990

Over the past 25 years, quality assurance efforts have made major strides forward, but have still to fully address health and long term care quality in many settings, including ambulatory and home care. Further, much of it is tied primarily to Medicare, and, to a lesser extent, Medicaid; whereas the privately insured and uninsured have little protection.

Medicare and Medicaid also have many gaps as to services and persons covered. The Catastrophic Care Act of 1988, repealed in 1989, identifies one set of services that are not covered. There are long term care services, dental services, and other services that are not covered by these programs. Another gap is that Medicaid only covers 42 per cent of persons below the poverty line. Medicaid also suffers from low participation by many hospitals, physicians, and other providers.

A further gap of great importance is the number of persons who are un- and underinsured. Studies show that the number of persons who have no health insurance has grown from 28 to 37 million persons between 1979 and 1986 (see Figure). When facing a catastrophic acute or long term illness, over 200 million Americans are underinsured.

Nonelderly Without Health Insurance
1979 and 1983 to 1986



Source: Current Population Survey, Census Bureau

FUTURE FEDERAL ROLE IN HEALTH AND LONG TERM CARE. Fortunately, there are many reform proposals on the table from a wide spectrum of organizations, coalitions, and members of Congress. One set of proposals represent expansions and improvements to the Medicare and Medicaid programs.

A second set of proposals are designed to bring about comprehensive health and long term care reform. Some, such as Congressman Roybal's USHealth Act (H.R. 2980), lean toward a federally-based, nationwide program built upon Medicare and covering health and long term care. Some comprehensive proposals, like the Pepper Commission recommendations, use employer-mandated health insurance, Medicare and an improved Medicaid-type program to ensure health and long term care protection. In addition, more and more interest is also being shown in using part or all of Canada's system as a basis for comprehensive reform. What is promising is that comprehensive reform continues to pick up supporters from a broad spectrum of the American public and that there is a substantial openness to different approaches, as long as they accomplish the goal of ensuring protection for all Americans.

Looking to the future, the nation has two responsibilities. The first responsibility is one of stewardship over Medicare and Medicaid as they are today. The second responsibility is to those who have yet to benefit from this nation's greatest step forward toward protecting its citizens' health.

When millions live at risk and in fear of a long term disabling illness wiping out the financial and emotional resources of their families, a nation cannot be satisfied with Medicaid as the nation's primary long term care policy. When millions are forced to seek charity for whatever health care they need, a nation can feel no pride in having the best medical care in the world.

In a world which has increasing doubts over the United States' ability to step forward and show leadership on the great issues of the day, health and long term care protection is one case where this nation not only fails to lead but fails to keep up. Twenty five years would seem to have been enough time for this nation to take its rightful place of leadership; thirty years would seem to be too long.

[See Appendix I, p. 89 for report submitted by Chairman Roybal.]
The Chair now recognizes Mary Rose Oakar.

STATEMENT OF REPRESENTATIVE MARY ROSE OAKAR

Ms. OAKAR. Thank you, Mr. Chairman. First of all, I want to compliment you, the distinguished chairman of the Aging Committee. You, too, have had a brilliant career in being for the people of this country. This is another living testament. When people are talking about cutting these programs, you've always been staunchly supportive of the programs and have offered many areas of improvement.

Medicare and Medicaid really relate to about 55 million people. I think one of the great society's contributions, and one of the areas that President Johnson does not get a lot of credit for, is the fact that it was under his administration that these fine programs took place. Here we are 25 years later with a crisis on hand. These programs accommodate a certain number of people, but we have an additional 37 million people without any insurance, another 40 million who are underinsured, and I personally feel very, very strongly that we ought to have universal health coverage for every American and long-term care. I've introduced a bill to that extent.

I also was pleased, Mr. Chairman, and my colleagues, to serve on the Pepper Commission with Senator Pepper as the chair and, when he passed away, we were very fortunate to have elected Chairman Rockefeller, who was very, very fair to all the 15 Commissioners, especially to me.

I think the Pepper Commission report will be a report that will be long remembered. My only hope is that we implement it soon because we really do have a crisis. This kind of hearing should be a reminder to us 25 years later that our task isn't finished. Claude Pepper did have one unfulfilled dream in his 50 years of public life, and that was that he wanted every single American to have access to health insurance in a comprehensive way, and that included long-term care.

So let's recommit ourselves on this anniversary and rededicate ourselves to that end.

Thank you, Mr. Chairman.

[The prepared statement of Representative Oakar follows:]

Statement of Representative Mary Rose Oakar
The House Select Committee on Aging
July 30, 1990

Chairman Roybal, I am pleased to have the opportunity to be a part of today's hearing -- a hearing to reflect on 25 years of the Medicare and Medicaid programs in the United States. These two programs have, without a doubt, greatly improved the quality of life for millions poor, elderly, and disabled Americans, and I join my colleagues and our distinguished guests in thanks to you, for calling this hearing to mark the passing of this special day.

Mr. Chairman, twenty-five years ago today, on July 30, 1965, President Lyndon B. Johnson signed into law the Medicare and Medicaid program. It is ironic that, at that time, these two successful and highly popular federal government programs came under the very same attack that current proposals for universal national health care plans engender. Only a few years prior to passage of these programs, Senator Claude Pepper was burned in effigy for advocating a system of national health care. These programs from their conception prompted rancorous public debate. The Medicare and Medicaid concepts were characterized as "socialism" and "socialized medicine." Proponents of this minimum standard of decency for indigent, disabled, and elderly citizens were branded as "communist." This hearing in part should be a testament to the courage and vision of those Members of Congress who voted these programs into law. Thirty-three of these Members remain in office, and I am aware, Mr. Chairman, that you are among them.

Today, I know of no Members of either body who would vote to do away with these programs, except perhaps to replace them with something more comprehensive. The Medicare program currently supplies needed health care to 33 million older and disabled Americans, and Medicaid remains the only viable alternative for insurance coverage for 23 million of the nation's poor. The historic enactment of these programs set a precedent for a minimum standard of health coverage for our citizens -- these programs imply a basic right to health care for all Americans.

Mr. Chairman, as the committee's report points out, although Medicare and Medicaid have greatly improved the overall health and standard of living of many Americans, they fall far short of the goals envisioned by the original sponsors. I had the good fortune to serve on the Pepper Commission under the stewardship of Senator Rockefeller, who has joined us today, as we grappled with the realities that 37 million Americans have no health insurance today, that another 40 million are inadequately insured, that the vast majority of the uninsured either work, or are members of families with at least one member who works, that virtually no one in the United States can get coverage for long-term care without spending their life's assets down to Medicaid.

Medicare only covers 45 percent of the health care needs of older

and disabled Americans. Subsequently, Medicare recipients must rely on expensive supplemental policies which are also inadequate and confusing as to their relative worth. Our obsession with covering only services deemed "medically necessary" in the name of cost containment, is actually driving health care costs. Most insurance plans in the United States, public or private, do not cover, home health benefits, immunizations, or other preventive care such as periodic colo-rectal exams, mammography screening, pre-natal care or general wellness programs. Annual physical exams are an uncommon benefit. Almost all of these types of benefits would actually save our nation a great deal of money, if we covered them comprehensively in our public and private health plans.

The Medicare and Medicaid programs are also grossly underfunded. Medicare has been cut by more than $30 billion over the last decade. The result is that more than two-thirds of all U.S. hospitals lost money caring for Medicare patients in FY89. The average hospital payments were 8-9 percent less than costs. DRGs have resulted in many patients being released from hospitals "quicker and sicker." All to often these patients eventually return to the hospital due to inadequate follow up. An increasing responsibility for the care of the indigent has been shifted from the federal government to the states in recent

years, and innovative efforts by the States to raise revenues for the Medicaid program, such as Ohio's Care Assurance program have come under attack by the federal government.

In spite of all of these shortcomings these programs are still giving Americans a better value for their dollar than many private-sector plans. Looking at loss ratios alone, Medicare returns 97 percent of it premiums in the form of benefits. The federal minimum standard for most private plans is 75 percent. Many private sector insurance plans do not meet this minimum loss ratio standard.

I'm for throwing in the towel on piecemeal approaches. Americans spend far more than any other industrialized nation on health care, and yet one-eighth of our population falls between the cracks. We are the only industrialized nation other than South Africa with no national health plan. In the spirit of the enactment of the Medicare and Medicaid programs, Americans should embrace a comprehensive, national plan for universal access to health and long-term care coverage for all Americans, such as the one set down in my legislation H.R. 4253. Sixty-seven percent of all Americans recently polled endorse the concept. Mr. Chairman, I thank you for calling these distinguished witnesses before the Committee today. I look forward to their testimony.

The CHAIRMAN. Thank you, Ms. Oakar.
The Chair recognizes Mr. James.

STATEMENT OF REPRESENTATIVE CRAIG T. JAMES

Mr. JAMES. Thank you. I want to congratulate the Chairman for all of his work in the past and all of his work that I'm sure that he's prepared to do in the future.

I think there would be no better birthday present that we could give to Medicare and Medicaid, and to ourselves, and to our 55 million that utilize the system, and to the youth of this world than to move in the direction in a very firm, correct way toward resolving the health care crisis that we have, both for young and old, but most specifically for the elderly.

I am most interested in the testimony that we will hear today, and expansion on the figures as to what we may expect or anticipate. I'm most interested in hearing of the figures that are estimated in regard to the additional cost-that in addition to the $62 billion that we may find that business would experience under the Pepper Commission program, if anyone has those figures, so that we can look at the total package.

We spend a very high percentage of our GNP, estimated between 12 and 13 percent, somewhere in that range—certainly it appears that we spend a significant percentage of our gross national product. The question is: how can we redesign, if we must, the delivery system that we have so as to resolve those 37 million uninsured as well as the 55 million of the elderly? That is, I think, one of the primary—it is one of the two primary, along with our economy, problems facing Congress this year, and next year, and probably the next.

We need to move on and get onto our business and take it seriously. Hopefully we can make some tremendous moves this year in that direction.

Thank you. I look forward to hearing the testimony.

The CHAIRMAN. Thank you. At this time, if there are no objections, I would like to submit the prepared statements of several of my colleagues. Hearing no objections, so ordered.

[The prepared statements of Representatives Thomas J. Downey, Louise M. Slaughter, Jerry F. Costello, Helen Delich Bentley, and Constance A. Morella follow:]

STATEMENT OF THE HONORABLE THOMAS J. DOWNEY
CHAIRMAN, SUBCOMMITTEE ON HUMAN SERVICES

July 30, 1990

As the Chairman of the Subcommittee on Human Services, I would like to congratulate Chairman Roybal for calling this hearing today, and for unveiling the Aging Committee's new report on the 25 year history of the Medicare and Medicaid programs and the part they will play in providing health and long term care protection for Americans in the future.

Twenty five years ago, during the summer of 1965, Congress passed and the President signed a number of landmark bills which form the foundation of many of our social programs for older Americans today. During one Congress, years of effort by older Americans and their advocates were capped by enactment of the Older Americans Act and the Foster Grandparents Program, both of whose silver anniversaries have recently been celebrated, and finally, Medicare and Medicaid, whose silver anniversary we celebrate today. Strong Presidential and Congressional leadership made possible the greatest expansion in health and human service legislation since the New Deal.

Today, Medicare provides health insurance coverage to approximately 30 million persons over 65 and 3.3 million disabled persons. Together with Social Security, Medicare provides the basis for retirement planning for millions of men and women. Without Medicare, they would have to bear the full cost of all their hospital and doctor bills. Many older people would not otherwise be able to afford the health care they need and deserve. Medicare is not a perfect program -- and it has been adversely affected by the budget cuts of the last ten years -- but without it countless numbers of older Americans would face impoverishment due to medical bills.

Medicaid has in recent years become the major Federal funder of long term care, but only for those older Americans who are cared for in nursing homes or other institutional settings. This severely strains the Medicaid program, accounting for 30% of Medicaid's budget. This strain will only increase if we fail to address the problems of long term care in a comprehensive manner.

The purpose of today's hearing -- to examine the promise of Medicare and Medicaid when first enacted -- and how that promise has been met -- will provide us with a much clearer insight into what work we have ahead of us. Clearly, there are deficiencies in both the Medicare and Medicaid programs, deficiencies that currently leave approximately 37 million Americans uninsured. Deficiencies that leave over 200 million Americans lacking long term care protection. Deficiencies that force elderly Americans to pay a higher percentage of their income for health care than they have in the past.

We must continue to show our commitment to the elderly and the disabled of our Nation. Twenty five years ago, this commitment was called courageous and compassionate. Americans today are beginning to doubt the sincerity behind that sentiment. It is our responsibility to complete the task begun a quarter of a century ago, and ensure that all Americans have the health care security they are entitled to and deserve.

I look forward to hearing the testimony today of our distinguished panel of witnesses.

Statement of Congresswoman Louise M. Slaughter
before the
Select Committee on Aging

July 30, 1990

I thank the Chairman for calling this hearing this afternoon. It's hard to believe that Medicare celebrates its twenty-fifth year in 1990. When I look around at the state of American health care today, I see more than 37 million Americans without health insurance. I see a growing homeless population with no access to health care at all. I see millions of senior citizens and their loved ones spending themselves into poverty in order to pay for long term care. All this when we have two popular health insurance programs for America's poor, disabled and elderly. I shudder to recall the state of American health before the Medicare and Medicaid programs were enacted.

For twenty-five years, Medicare and Medicaid have provided much needed help and comfort to some of this country's most vulnerable citizens; but they have not been a panacea for all that ails our health care system. Today we recognize the unfinished agenda for providing health and long term care protection to all Americans. Congress took a step toward realizing that goal when we passed the Medicare Catastrophic Coverage Act in 1988. Our experience with that program and its eventual repeal taught policy-makers a valuable lesson. What we didn't know then is painfully obvious now -- reversing the growing crisis in health care will not come through piecemeal or band-aid approaches. The gaps are too large and too numerous. The costs

are increasing too rapidly.

I join my colleagues on the Select Committee on Aging in reiterating our commitment to solving the problems of health and long term care. I very much look forward to the testimony presented here today, as well as a careful study of the Chairman's report on the 25 year history of the Medicare and Medicaid programs and their future role in providing health and long term care protection for Americans of all ages. This is certainly one of the most pressing issues of the 90's, and one which will be a top priority for the Congress until all Americans are assured their basic right to health care.

Again, I thank the Chairman for calling this hearing today. Let me also express my appreciation to the witnesses who have taken the time to be with us this afternoon and share their own important ideas on the past, present and future of Medicare and Medicaid. I look forward to hearing from all of you.

OPENING STATEMENT
BY U.S. REP. JERRY F. COSTELLO
HOUSE SELECT COMMITTEE ON AGING
JULY 30, 1990
"MEDICARE AND MEDICAID'S 25TH ANNIVERSARY -- MUCH PROMISED, ACCOMPLISHED, AND LEFT UNFINISHED"

MR. CHAIRMAN, I AM PLEASED TO BE HERE TODAY AS THE SELECT COMMITTEE ON AGING EXAMINES THE HISTORY OF MEDICARE AND MEDICAID. IN THE 21ST DISTRICT OF ILLINOIS AND THROUGHOUT THE NATION, THIS ISSUE IS OF GREAT IMPORTANCE. I AM CONFIDENT THIS HEARING WILL PROVIDE US WITH A BETTER UNDERSTANDING OF MEDICARE AND MEDICAID AND GIVE US VALUABLE INSIGHT AS WE EXAMINE POSSIBLE STEPS TO ENSURE ACCESSIBLE HEALTH CARE FOR ALL OF OUR CITIZENS. I AM LOOKING FORWARD TO HEARING THE TESTIMONY OF THE DISTINGUISHED PANEL OF WITNESSES.

MR. CHAIRMAN, I AM CONCERNED THAT HEALTH CARE COSTS HAVE BEEN RISING AT RATES MORE RAPID THAN THE COST OF LIVING. IN FACT, BETWEEN 1983 AND 1989 MEDICAL CARE PRICES ROSE AT TWICE THE RATE OF INFLATION. AT A TIME WHEN MEDICAID ONLY COVERS FORTY-TWO PER CENT OF PERSONS BELOW THE POVERTY LINE, THE TIME HAS COME TO REASSESS OUR CURRENT HEALTH CARE PAYMENT SYSTEM.

TWENTY-FIVE YEARS AGO ON JULY 30, 1965, PRESIDENT JOHNSON SIGNED INTO LAW THE MEDICARE AND MEDICAID PROGRAMS AS TITLES XVIII AND XIX OF THE SOCIAL SECURITY ACT. THESE PROGRAMS HAVE GONE THROUGH

MANY CHANGES IN THEIR TWENTY-FIVE YEAR HISTORY, AND MANY IMPORTANT CONTRIBUTIONS HAVE BEEN MADE TO THE HEALTH CARE NEEDS OF THE ELDERLY, DISABLED, AND THE POOR. I CAN THINK OF NO BETTER TIME THAN ON THIS ANNIVERSARY OF MEDICARE AND MEDICAID TO REVIEW THIS SYSTEM AND WORK DILIGENTLY TO ENACT POSITIVE REFORMS TO BETTER OUR HEALTH CARE SYSTEM TO MORE EFFICIENTLY MEET THE NEEDS OF OUR NATION.

THANK YOU, MR. CHAIRMAN, FOR CALLING THIS HEARING AND FOR YOUR CONTINUED LEADERSHIP OF THIS COMMITTEE.

OPEN

STATEMENT OF HELEN DELICH BENTLEY
BEFORE THE
HOUSE SELECT COMMITTEE ON AGING
ON MONDAY JULY 30, 1990

Good afternoon Mr. Chairman, I would like to take this opportunity to thank you for bringing us together today to discuss --- in retrospect --- a monumental program that has touched the lives of untold millions of Americans.

Since its creation 25 years ago, the Medicare program has made quality health care more accessible to many Americans who might otherwise suffer. However, we continually must strive to ensure that their health care needs continue to be met.

During this 101st Congress, major portions of Medicare, Medicaid and other health care programs continue to be debated. Our distinguished colleague on the Senate side, Mr. Rockefeller, spearheaded a sweeping review of the nation's health care system --- a difficult undertaking that has earned him great respect. Despite the flurry of activity however, issues such as coverage for catastrophic health care, long-term care, AIDS, prescription drugs and reimbursements to urban hospitals remain crucial areas of concern.

Huge increases in health care costs have imposed tremendous burdens on many patients --- we are all aware of the fact that health care costs are rising far more sharply than the rate of inflation, everything from diagnostic work to doctor's fees. Although there is no simple or single solution, we need to continue to devise cost containment strategies to guard against plummeting America deeper into debt. We need to do it for our older Americans who receive care and for the population in general, which pays for that care and will also require it one day.

Thank you again Mr. Chairman, I look forward to hearing the remarks of the distinguished witnesses.

HON. CONSTANCE A. MORELLA

JULY 30, 1990

OPENING STATEMENT

MR. CHAIRMAN, THANK YOU FOR SCHEDULING THIS HEARING TODAY ON THE 25TH ANNIVERSARY OF THE START OF MEDICARE AND MEDICAID.

TWENTY FIVE YEARS AGO, CONGRESS AND THE PRESIDENT INITIATED A HISTORIC STEP IN PROVIDING MANY NEEDED HEALTH SERVICES TO THE ELDERLY, THE DISABLED, AND LOW-INCOME INDIVIDUALS. HOWEVER, WE ARE ALL TOO AWARE TODAY OF THE MANY GAPS IN THAT SYSTEM, PARTICULARLY THE LACK OF LONG-TERM CARE PROTECTION FOR THE ELDERLY AND THE LACK OF HEALTH INSURANCE FOR MANY AMERICANS.

I LOOK FORWARD TO HEARING THE TESTIMONY OF OUR WITNESSES TODAY AS WE LOOK TO THE FUTURE OF THESE VITAL PROGRAMS. I URGE MY COLLEAGUES TO WORK TOGETHER TO ADDRESS THE SERIOUS GAPS IN HEALTH COVERAGE FOR OUR CITIZENS.

The Chair now recognizes Senator Rockefeller. Would you please proceed in any manner that you may desire?

STATEMENT OF THE HONORABLE JOHN D. ROCKEFELLER, IV, A UNITED STATES SENATOR FROM THE STATE OF WEST VIRGINIA; AND CHAIRMAN, U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE (THE PEPPER COMMISSION)

Senator ROCKEFELLER. Thank you, Chairman Roybal, very much. I look forward to seeing you as one of the honored guests this evening because you, as a relatively few number of others from the Congress were here 25 years ago when this legislation passed. That ceremony tonight should be very emotional and very meaningful to you.

I have to reflect, obviously, on the comments you made about Claude Pepper and that Mary Rose Oakar made about Claude Pepper—the power of that man, the dream of that man. Just as you, in a much more significant way, of course, have taken the seat, I, in a much less significant way, was honored to work with your colleague, Mary Rose Oakar, and others from the House and the Senate and three who were appointed by President Reagan on the Pepper Commission, and I was lucky enough to become its chairman.

So what today is about I think generally, not just this hearing, but all of what goes on today, is about trying to continue his drive to make sure that every single American has access to care and also every single American who needs long-term care can get it. Neither of those, of course, is true today.

Medicare and Medicaid's 25th anniversary is a cause for celebration, as you have indicated, and also some reflection. The Congress and the President committed themselves to ensure access to health care for the old and for the poor the first time in a great and extraordinary event. I would agree with Congresswoman Oakar, President Johnson is due much more credit than he received for that. And it's a celebration, I think, because those programs are fundamentally successful. They provide a means for millions of Americans to get health care that they otherwise would not be getting today.

And so, therefore, I applaud you for this hearing, even as we both remember that what we're looking at is the future, remembering the password pushed by Chairman Pepper to make sure that all Americans have access to health care and that all Americans who need long-term care can, in fact, get it.

Our country, Mr. Chairman, I think is accustomed to accomplishing goals in incremental steps. Sometimes that works, and sometimes that doesn't work so well. The authors of Medicare and the authors of Medicaid believe that limited public programs might provide the Government with important lessons as to how to build towards universal health care as a system.

I think that assumption has proven fundamentally to be true. We've learned a great deal about how to help people get health care. When Medicare went into effect in 1965, there were about 19 million elderly people enrolled in that program. In 1972, two other groups came into that program. One was the disabled; others were

people who suffered from end-stage renal disease. And so today over 33 million people get benefits from Medicare.

Major accomplishments of the Medicare program include reduced mortality rates among the elderly and a significant reduction, interestingly, in the disparity between health services used by black and by white Americans.

Medicaid, too, has made important accomplishments. Because of Medicaid the number of poor people who see a physician has risen enormously. Actually, it's interesting that the number of poor who see a physician actually exceeds that for those with high incomes. But then, on the other hand, part of that reflects the greater need for health care among the poor and especially in adult and older age groups.

In any event, the Medicaid program has had a major role in filling in the gaps of Medicare for health care and, of course, long-term care for low-income, elderly, and disabled people.

Now having talked about that, what lessons have we learned from our 25 years of experience? We've learned that Medicare is a federally run universal program, and that it is loved, and that it is cherished by millions of its beneficiaries. We have learned that the clout of a national program gives us the ability to control costs, and we find that we are beginning to experiment in using that clout in terms of finding ways to control costs. Physician payment reform gave an indication of the direction.

We are also experimenting with ways to use managed care much more aggressively—managed care options in a national sense. We have also learned that there are shortcomings in the Medicare program. Poor and near poor individuals are still heavily at risk for financial out-of-pocket of costs. And, of course, the most significant and really unbelievable part is that Medicare lacks any sort of coverage for long-term care services.

I chair a subcommittee in Senate Finance which has always bewildered me. It's called "Medicare and Long-Term Care." I don't know—somebody must have gotten the words confused. And, of course, the elderly and the disabled want and need long-term care.

Now while Medicaid has made great strides in assisting low-income people, Mr. Chairman, we have learned a lot from Medicaid, in my judgment, about how not to run a Federal program, or to run any program. The original Medicaid law contained language that required States to move towards comprehensive care for all needy people, but that goal was abandoned when the provision was repealed in 1972.

Medicaid now covers only 42 percent of those who it is meant to, those whose income is under 100 percent of the Federal poverty line on an annual basis. Of course, there are a number of reasons for this. Medicaid is limited by Federal law to whom it can cover, to the folks that it can cover, only certain categories of people, and then each State sets its own income eligibility standards.

I need not tell the chairman what extraordinary variation and wretched variation there is from State to State on that. I won't mention any States, but I could. I makes me very angry when I think about what States put in the way of the poor in becoming eligible for Medicaid.

Of course, the States themselves have experienced difficulty in controlling the cost of their program, so I can't be entirely harsh. So they have to respond to those cost pressures by limiting their eligibility criteria, and they do that very dramatically.

Also, they can limit the services they cover and the reimbursement rates that they pay providers. Reimbursement rates, in fact—and this I think is one of the real problems with Medicaid—are so low in some places that those who are eligible and do have Medicaid cannot find doctors who will treat them. That is classic. That is classic in too many of our States.

So the States on the one hand have been successful in experimenting with local delivery designs but, on the whole, Mr. Chairman, I think you have to say that this sort of patchwork of State-by-State rules and regulations, eligibility criteria, benefits, et cetera, renders Medicaid not the model, if I might say, that the much more efficient Federal Medicare program is.

So where do we go from here? Many problems remain. Even with Medicare and Medicaid in place, some 32 million have no health coverage at all. I was interested that the Congresswoman indicated 31 million, and the Congressman indicated 37 million. I, in fact, have stopped using 31 or 32 million. I prefer to say what I think is more accurate, and that is that over a period of 28 months, 63 million Americans will not have access to health insurance during significant portions of that time.

The 31 million is a dipstick measurement, but the more accurate and the more painful, I think, is the one that goes over a 28-month period. Coverage from employers is eroding. Chrysler, as we all know, spends more on health care than they do on steel. Small business is increasingly discouraged. People are beginning to walk away from benefits in business because they can't afford the health insurance, so Americans are at risk of needing, but not being able to pay for, health care and long-term care.

It is time to take the lessons that we have learned over these 25 years and put them to use in finally building a universal health system.

The Pepper Commission, which Mary Rose Oakar referred to and served on brilliantly, made recommendations and I think made, on balance, very good recommendations, solid recommendations, enactable, doable recommendations, Mr. Chairman, that build on the strengths of the current system.

I, myself, believe that we have about 6 or 8 years in this country left in order to make the current health system work. I think if we don't make it work within that period of time by enacting the Pepper Commission's recommendations, or others similar to it, the American people are going to rise up as we saw them do a summer ago in catastrophic health care, and they are going to demand some kind of national health insurance system, but it will not be what we have.

Of course, if it's national health insurance, it's going to be $288 billion. But when people decide that they are disgusted with the health care that they are receiving, or it's insufficient, or insurance rates are out of sight, they will not be patient. They will force us to move on to something else.

So building on the current system, I think, is urgent. We create a federally run public program for the under 65 population with uniform services nationwide and a uniform reimbursement system that provides, in fact, adequate rates of reimbursement for providers. That's important. Eligibility is not limited to the poor. Anyone can enroll, but the premiums are subsidized for only the poor and for the near poor.

For the over 65 population, we help more low-income people with Medicare premiums and cost sharing and we improve on the current Medicare benefit package. We understand that the Government cannot do the whole job by itself, and so we ask employers to continue to do their share—in fact, increase the share that they are doing by providing coverage for their workers and for their families which, in fact, most employers already do.

We help employers do this, particularly small employers, 25 and under, by providing direct subsidies of premiums—very dramatic stuff, I might say, Mr. Chairman. We bend over backward to try and make it possible for small business to afford health insurance. It's one thing to say, "Get it," but if they can't afford it, it doesn't do much good. So we'd use a variety of inducements and seductions, so to speak, to try to—and we think successfully get them to buy health care insurance that they can afford.

We also recognize that universal access potentially helps control costs, and that controlling costs is an overwhelmingly crucial component of ensuring the viability of health care or having health care for all of us in the future. We've got to be able to control costs.

The Pepper Commission, Mr. Chairman, felt that the current $660 billion was going to go to about $1.5 trillion by 1990. Now Stuart Altman, and others on Propac, are figuring that it may be closer to $1.8 trillion or $2 trillion by the year 2000, and I put that in perspective merely by saying that we have a $5 trillion economy. That would be 40 percent. That's not quite doable.

Now because assistance for long-term care is almost nonexistent for all but the poorest people, we in the Pepper Commission created a new public plan that helps disabled people of all ages. We do not discriminate on age—not just under 18, not just over 65, anyone. We emphasize home care and community-based care, and then we also have nursing home care. We provide incentives for people to purchase private long-term care insurance, which is now—we give it full deductibility, which it does not have and we strengthen consumer protections for those who do.

I conclude, Mr. Chairman, by simply saying, as have you, that the time for action has once again arisen. Twenty-five years is a long time. Twenty-five years is no time. We should be proud of these important steps that have been taken, but we must also recognize that these steps are only steps along a path, along a journey which is far from finished, that in a country with majestic economic strength we are far from majestic in the way we do health care in terms of our people who need it, those who can't afford it. We do have at least a two-tiered system, so we must close the gaps of coverage that remain. We must commit ourselves, as the Congress and the Chairman did 25 years ago, to finish the job.

I thank the Chair.

[The prepared statement of Senator Rockefeller follows:]

The Pepper Commission

United States Bipartisan Commission on
Comprehensive Health Care
140 Cannon House Office Building
Washington, D.C. 20515
(202) 225-9950
Fax 225-6653

STATEMENT OF

SENATOR JOHN D. ROCKEFELLER IV, CHAIRMAN

U.S. Bipartisan Commission on Comprehesive Health Care

(The Pepper Commission)

Before

House Select Committee on Aging

on

"Commemoration of Medicare and Medicaid's 25th Anniversary"

July 30, 1990

Mr. Chairman and members of the committee, thank you for inviting me to speak to you today on the occasion of the 25th anniversary of Medicare and Medicaid. Mr. Chairman, both of us have succeeded Claude Pepper in the roles we are filling today, you as chair of the Select Committee on Aging and me as the chair of the Pepper Commission. We both know how hard it is to fill his shoes. This hearing, today, continues his drive for access to health and long-term care for every person in this country.

This 25th anniversary calls for celebration because it brings to mind a time when Congress and the President committed themselves to ensure access to health care for our most vulnerable citizens, the old and the poor. This anniversary also calls for celebration because, indeed, these programs are a success. They provide a means for millions of Americans to get care they would not otherwise be able to obtain. I applaud you for holding this hearing to review the progress of the last 25 years in health care policy and to provide the opportunity for us to discuss the next steps the United States must take to ensure access to care for all Americans.

Our country is accustomed to accomplishing goals in incremental steps. The authors of the Medicare and Medicaid programs believed that limited public programs might provide the government with important lessons on how to build a universal system. That assumption has proved to be true. We have learned a great deal about how to help people get health care.

When Medicare went into effect in 1965, over 19 million elderly people enrolled in the program. In 1972 two other groups

of people were given benefits, the disabled and people who suffer from end stage renal disease. Today over 33 million people get benefits from Medicare.

Among the major accomplishments of the program are reduced mortality rates among the elderly and a significant reduction in the disparity between health services use by black and white Americans.

Medicaid, too, has made important accomplishments. Because of Medicaid the number of poor people who see a physician rose; for the poor on the program, the number of visits to a physician actually exceeded that for high-income families, reflecting the greater health care needs among the poor, especially in adult and older age groups. The Medicaid program has had a major role in filling the gaps in Medicare for health and long term care for low-income elderly and disabled people.

What lessons have we learned from our 25 years of experience? We have learned that Medicare, a federally run universal program, is loved and appreciated by the beneficiaries. We have learned how to administer a nationwide program efficiently. We have learned that the clout of a nationwide program gives us the ability to control costs and we are experimenting with ways to best use that clout. We are also experimenting with ways to incorporate local managed care programs into the national scheme.

We have learned that there are shortcomings in the program also. Poor and near-poor people are still at risk of heavy financial out of pocket costs for care. Most significant is the

lack of coverage of long-term care, services which the elderly and disabled both sorely need and want. And the cost containment mechanisms we are developing in Medicare are urgently needed, since the costs for the program have escalated alarmingly.

While Medicaid has made great strides in assisting low-income people, we have learned much from Medicaid about how not to run a program. The original Medicaid law contained language that required states to move toward comprehensive care for all needy people, but that goal was abandoned when the provision was repealed in 1972. Medicaid currently covers only 42% of the population whose income is under 100% of the federal poverty line. There are a number of the reasons for this -- Medicaid is limited by federal law to only certain categories of people, and each state sets its own income eligibility levels which vary dramatically from state to state.

States have experienced difficulty in controlling the cost of their programs and have responded to pressures by limiting their eligibility criteria, the services they cover and the reimbursement rates they pay providers. Reimbursement rates are so low in some places that Medicaid beneficiaries cannot find doctors who will treat them. While the states have been successful in experimenting with local delivery designs, in general the patchwork of state by state eligibility, benefit and reimbursement rules have not worked as well as the more efficient federal Medicare program.

Where do we go from here? Many problems remain. Even with Medicare and Medicaid in place, some 32 million people have no

health coverage at all. Coverage from employers is eroding, and small employers find insurance more unaffordable and inaccessible every day. All Americans are at risk of needing, but not being able to pay for, long-term care. It is time to take the lessons we have learned and put them to use in finally building a universal health system.

The Pepper Commission, which I have the honor to chair, made recommendations that build on the strengths of our current system. We create a federally run public program for the under-65 population, with uniform services nationwide and a uniform reimbursement system that provides adequate and controlled rates for providers. Eligibility is not limited to the poor. Anyone can enroll, but the premiums are subsidized for the poor and near-poor. For the over 65-population we help more low-income people with Medicare premiums and cost-sharing and improve on the current Medicare benefit package.

We understand that the government cannot do the whole job by itself so we ask employers to do their share by providing coverage for their workers and families -- as most already do. We help employers do this by making insurance more affordable and accessible, by providing direct subsidies of premiums and by providing a period of voluntary compliance for small businesses.

We also recognize that universal access helps control costs and that controlling costs is a crucial component of ensuring the viability of quality health care system for all of us.

Because assistance for long-term care is almost nonexistent for all but the poorest people, we create a new public plan that

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helps disabled people of all ages get home care and nursing home care. We also provide incentives for people to purchase private long-term care insurance, and strengthen consumer protections for those who do.

The time has come for action. Twenty-five years ago we acted to provide assistance for the elderly and poor. We should be proud of those important steps. But, we also recognize that though significant, they were only steps along the path we must tread. Now we must continue the journey. We must close the gaps of coverage that remain. We must commit ourselves, as Congress did 25 years ago, to addressing the needs of the people.

The CHAIRMAN. Thank you very much, Senator.

I've been informed by my staff that it will be necessary for you to return to the Senate. As you know, it is customary that we ask a series of questions, but that will delay you for the next hour. So I'm going to use the prerogative of the Chair and ask only one question, which I think is a question that most Members would be asking themselves. With regard to the statement that you made regarding building on the strength of the present system, I think we agree with that. At least I do.

What I've heard criticisms about has been the financing plan. In the recommendations that the Commission has made, do you propose a plan that is progressive, and is it one that is applicable to all?

Senator ROCKEFELLER. Yes. And it's progressive in the sense that our criteria for raising the money for it, which incentive will be much more carefully spelled out in our September full report, are based upon three principles. One is that it has to be according to ability to pay. Secondly, it has to be across all ages because all ages participate. And, thirdly, the taxes chosen must be of such a nature that they rise quickly enough so as not to cause new forms of taxation to be added on. Secondly, we, in our proposals, don't just suggest that every American have access to health care.

The CHAIRMAN. All right. The one last thing then is with—

Senator ROCKEFELLER. We mandate it.

The CHAIRMAN. [continuing] regard to your report, that is, the Commission report to be released late in September. Will that report actually outline a plan that could be used as one that—let's say the Commission and the Congress can use in bringing about a national health plan eventually?

Senator ROCKEFELLER. Absolutely. We lay down for access to health care a 6- to 7-year implementation plan, which could be enacted immediately and then done over a period of 6 or 7 years. As for long-term care, we have a four-phase plan, which could be phased in in the manner that we suggest. But it's enactable. We did not do everything in long-term care that we would have liked to have because enactability, doability, signability, so to speak, were a part of our criteria.

The CHAIRMAN. But in the September report, you will have a—

Mr. ROCKEFELLER. All will be laid out.

The CHAIRMAN. And that will include long-term care?

Senator ROCKEFELLER. Yes, sir.

The CHAIRMAN. All right. Thank you very much.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Senator, thank you very much for your appearance today and for an excellent testimony.

The Chair will now call the panel, which is made up of Dr. Gail Wilensky, Mary Bowden, Burt Lancaster, and Dr. Arthur Flemming.

Our first panel witness is Dr. Gail Wilensky, who is Administrator of the Health Care Finance Administration (HCFA). Today is her first appearance before the committee, and we appreciate her joining us on this "bittersweet" occasion.

As the Administrator responsible for Medicare and Medicaid and given her distinguished health policy credentials, we look forward to her views as to the lessons learned from these two programs.

We also look forward, Dr. Wilensky, to your insight into how we can build on a somewhat strained relationship between Medicare and its beneficiaries, and how we can move towards full health and long-term care protection for all Americans.

Dr. Wilensky, will you please proceed in any manner that you may desire?

A PANEL, CONSISTING OF GAIL R. WILENSKY, PH.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION (HCFA); MARY BOWDEN, CITIZEN; BURT LANCASTER, SCREEN ACTORS GUILD; AND ARTHUR S. FLEMMING, FORMER SECRETARY OF HEALTH, EDUCATION AND WELFARE

STATEMENT OF GAIL R. WILENSKY, PH.D.

Dr. WILENSKY.Thank you very much. Mr. Chairman and members of the committee, I am pleased to be here this afternoon to celebrate the silver anniversary of the Medicare and Medicaid programs. Together, we recognize 25 years of service to our Nation's most vulnerable citizens—the elderly and the poor.

Medicare and Medicaid have been very good programs. Over the years, they have provided health care security to tens of millions of Americans and their families. Today, we renew our commitment to the 54 million people who rely on Medicare and Medicaid. One in five Americans look to these programs to help them meet their basic health care needs.

We want to find ways to make these programs even more responsive to their needs, now and in the future. However, health care in this country has become increasingly expensive over the years, and Medicare and Medicaid bear some of the responsibility for the growth in health care spending.

Medicare and Medicaid now pay for more than one-quarter of national health care expenditures. In 1989, spending for these two programs totaled $157 billion. Medicare and Medicaid are the second and third largest Federal domestic spending programs after Social Security.

The administration recognizes the increasingly heavy burden society bears in paying for its health care. Last fall, the Secretary established a task force, led by the Under Secretary, to examine health care costs and access to health care. I serve as vice chair of that task force.

The President elevated the priority of these issues when he called for a Domestic Policy Council review of the quality, accessibility, and costs of our Nation's health care system. Secretary Sullivan will guide this review.

These efforts underscore the administration's highest level commitment to martialing the leadership, energy, and expertise necessary to address issues that touch so many Americans.

Our solutions must be uniquely American. The present private and public health care system should be the primary means by which we achieve our goals. We need to build on our achievements by getting an even higher percentage of people covered by insur-

ance. We must fashion methods of health care delivery and financing that constrain growth in health care expenditures. This will not be an easy process.

Along with Congress, we continue to engage in a struggle between the desire to provide more benefits to fill in the gaps and the necessity to curb spending. As we work together to improve Medicare and Medicaid, we must be careful that our actions do not contribute to inflationary trends. We must correct incentives that encourage unreasonable growth in spending, while preserving our commitment to quality health care.

Our immediate challenge is to reign in spending and to secure financial stability for Medicare and Medicaid. Our cost containment efforts focus on a simple goal—to secure a better value for our health care dollar. We need systematic approaches to provide incentives for appropriate and efficient use of health care services.

One successful approach—coordinated care—holds great promise for the future. Today, there are close to 2 million Medicare beneficiaries enrolled in coordinated care plans. Coordinated care systems, such as HMOs, offer beneficiaries a number of advantages over fee-for-service medicine. These include a more comprehensive range of services, less out-of-pocket costs, reduced paperwork, and help in navigating through our complex medical system.

HMOs and other managed care systems have demonstrated their ability to provide quality care at affordable prices. The administration wants to encourage more managed care options.

The Secretary recently sent a bill to Congress introduced by Representative Gradison which would give beneficiaries another choice. Our Medicare SELECT proposal would allow beneficiaries to enroll in preferred provider organizations.

These managed care systems would be linked to supplemental insurance to provide Medicare wrap-around coverage. While we think movement to coordinated care is most important, we will continue to reform the way we pay for Medicare services. We want to provide incentives in the payment system for efficient use of health services.

The physician payment reform will refocus incentives by generally increasing payment for primary care. Overall costs will be restrained through the use of the Medicare volume performance standards.

We are also committed to further payment reform by incorporating capital payments into the prospective payment system by October 1, 1991. Like cost containment, our activities to promote quality aim at deriving maximum value for our health care dollar.

Our efforts to improve quality are embodied in the Department's medical treatment effectiveness initiative. We are looking at what works in the practice of medicine. Outcomes research and practice guidelines will enhance the quality of American medicine. It will also help us to know that the investments we make in health care are necessary and appropriate.

I believe that informed consumers can make better choices about the care they receive. One of my top priorities is to make Medicare more understandable to the elderly.

Because this is so important, I have established a work group within HCFA to achieve this objective. The work group will present specific recommendations to me within the next few weeks.

I have also established a separate Medicaid bureau to give emphasis to programs serving our neediest populations. Our commitment to service has not wavered, but these are challenging times with difficult decisions ahead. Health care expenditures continue to increase at the same time the Federal budget has forced restraint in the growth of entitlement programs.

We must be cautious. Expansions to Medicare and Medicaid must be accompanied by the means and the willingness to pay for them. In the long-term, we must ensure that our health care system satisfies the needs not only of our Medicare and Medicaid populations, but all of our Nation's citizens. I feel fortunate to be in a position to work with you on making the necessary improvements to achieve this important objective.

Thank you for the opportunity to speak at this anniversary celebration. I would be pleased to answer any questions that you may have.

[The prepared statement of Dr. Wilensky follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Washington, D.C. 20201

STATEMENT OF

GAIL R. WILENSKY, PH.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

SELECT COMMITTEE ON AGING

HOUSE OF REPRESENTATIVES

JULY 30, 1990

Mr. Chairman and Members of the Committee:

I am pleased to be here this afternoon to celebrate the silver anniversary of the Medicare and Medicaid programs. Together, we recognize 25 years of health care service to our nation's most vulnerable citizens. Today I want to discuss the challenges we face as we renew our commitment to the poor and the elderly.

INTRODUCTION

July 30, 1965 marked an important day in the history of the United States. On this day, Medicare and Medicaid became law, and the resources of the nation's health care system became available to senior citizens and the disadvantaged.

Today we celebrate the 25th anniversary of Medicare and Medicaid. These have been good programs. Over the years, the basic health care protections offered by Medicare and Medicaid have helped tens of millions of Americans. These programs have brought a measure of security and comfort not only to those directly served, but in many cases to their families. But, while we have come far, we know we can make Medicare and Medicaid even more responsive and responsible.

We must, however, look to the future with a cautious eye. Medicare and Medicaid have fulfilled their promise of providing access to basic health care, but that health care has become

increasingly expensive. Many of the reasons for this are beyond our control, and reflect many forces, including social demand that at times seems unlimited. Some of the growth in health spending, however, clearly relates to incentives created by Medicare and Medicaid.

As the Administration and Congress consider changes in the roles Medicare and Medicaid will play in the future, we must be careful that our actions do not contribute to inflationary trends. We must correct incentives that encourage unreasonable growth in spending. Much of HCFA's efforts over the past five years have been directed toward this objective.

During my tenure as Administrator, I plan to enhance HCFA's activities to promote adequate, equitable, and predictable payment within reasonable levels of spending. I want to renew the commitment to meet our beneficiaries' needs, and to do it within the current budget climate.

BACKGROUND

Medicare and Medicaid have come a long way since the early years of the program. In 1967, the first full year of operation, Medicare and Medicaid served 30.5 million poor and elderly Americans, with Federal spending totaling $6.2 billion. In 1989, 54 million people, or one in five Americans, relied on these programs to meet their basic health care needs. Medicare and

Medicaid combined expenditures in 1989 totaled $157 billion.

Medicare and Medicaid pay for more than a quarter of all national health care. They are the second and third largest Federal domestic spending programs, following Social Security. These programs provide an important contribution to the health and welfare of our nation.

This Administration recognizes the increasingly heavy burden that society bears in paying for its health care. The nation's health care spending is growing three times faster than the rest of the economy.

In view of this situation, the Secretary established a task force, led by the Under Secretary, to examine health care costs and access to care. I serve as Vice-Chair of this task force. The President elevated the priority of these issues by requesting a Domestic Policy Council review, led by Secretary Sullivan, of the quality, accessibility, and costs of our nation's health care system. These efforts underscore the Administration's highest-level commitment to marshalling the leadership, energy, and expertise necessary to address issues that touch so many Americans.

This is not an easy process. Along with the Congress, we continue to engage in a struggle between the desire to provide

more benefits -- to fill the coverage gaps -- and the necessity to curb spending. The difficulty in resolving these seemingly conflicting objectives is strikingly demonstrated by the current budget summit efforts to meet the deficit reduction target.

Our immediate challenge is to rein in spending to a more reasonable level and to secure financial stability for the Medicare and Medicaid programs. At the same time, we need to reassess our health care priorities and consider different arrangements and incentives for delivering cost-effective health services.

It is in this context that I want to describe our initiatives since we last celebrated a major milestone in Medicare and Medicaid -- the 20th anniversary in 1985.

MEDICARE

Since 1965, Medicare has paid for services provided to 68 million beneficiaries. During this silver anniversary year, 34 million Medicare beneficiaries will receive almost $106 billion in benefits.

Today's Medicare beneficiaries will receive benefits far beyond the contributions they made to the Hospital Insurance Trust Fund. For individuals who become eligible in 1990, the average contributions made during their years of employment, including

interest, is nearly $7,500. We estimate they will receive almost $40,000 in Part A benefits. That's more than five times what they paid into the system. Under Part B, beneficiaries receive about four dollars in benefits for every one dollar in premiums they pay.

Since the 20th anniversary of Medicare, HCFA has focused its efforts on:

- Establishing a cost containment strategy that provides incentives for efficient utilization; and

- Strengthening our quality mechanisms to not only assure, but also to improve, the quality of care provided under the Medicare program.

COST CONTAINMENT

Our cost containment efforts focus on a simple goal: to secure better value for our health care dollar. We must look for innovative and systematic approaches to give consumers, providers, and physicians incentives that encourage appropriate and efficient utilization of health care services.

Coordinated Care -- One successful approach -- coordinated care -- holds great promise for the future. Coordinated systems of care encompass a wide variety of managed delivery arrangements

such as HMOs and competitive medical plans, or CMPs. Enrollment in Medicare managed health plans has steadily increased every year since 1985, the first year of the risk-contracting program. Today, there are almost 1.2 million beneficiaries enrolled in 96 risk-contracting HMOs and CMPs, and the number is rising.

Managed care offers beneficiaries a number of advantages over the fragmented approach of traditional fee-for-service. These include a more comprehensive range of services, lower out-of-pocket costs, and less paperwork. Beneficiaries receive greater continuity of care and get help in navigating through an increasingly complex medical system. Importantly, these coordinated care systems operate in a competitive environment, encouraging the efficient management of health care resources.

The Administration is committed to prepaid, managed care. HMOs have demonstrated their ability to provide quality care at affordable prices. We want to encourage even greater Medicare enrollment in managed care plans.

Payment Reforms -- While we think movement to coordinated care is most important, we will continue to work on payment reforms that promote the efficient use of health care services and give us better value for our health dollar.

We are committed to further hospital payment reform by

incorporating capital into the prospective payment rates by October 1, 1991. The current cost-based system for capital invites wasteful duplication and unnecessary acquisition of expensive technologies. We believe that incorporating capital into the prospective payment system will provide hospitals with a better incentive to make prudent capital decisions.
Medicare physician payment reform should also provide better incentives for appropriate use of health care services. The new fee schedule will refocus current incentives by generally increasing payment for primary care and reducing payment for surgery and other procedures. At the same time, the Medicare Volume Performance Standards will help restrain overall costs for Medicare physicians' services. And importantly, beneficiaries will be protected from excess billing charges under the new fee schedule.

We are also considering other cost-saving payment strategies including competitive bidding, extending prospective payment to other providers, "bundling" payments for services provided during an episode of care; and negotiating a package price for heart bypass surgery.

QUALITY

As we continue our efforts to contain costs, we must also ensure that our beneficiaries can rely on the quality of health care they receive under Medicare. As with our cost containment

strategies, our activities to promote quality care aim at deriving maximum value for our health care dollar.

The cornerstone of Medicare's quality assurance efforts is the peer review organization (PRO) program. PROs are charged with assuring that care is medically necessary, provided in the appropriate care setting, and that it meets professionally recognized standards of quality. PROs have shifted from their original focus on utilization to concentrate on quality problems. And PROs are now moving to test new review mechanisms, such as review in outpatient settings.

We believe PROs will continue to be an effective deterrent to substandard medical care. PROs, along with our program to inspect health care providers and monitor their compliance with Federal requirements, provide an assurance that care meets quality standards. Nevertheless, over the past several years, we have responded to the need to take action to improve the quality of care patients receive.

This is a primary motivation for the Department's initiative to pursue medical treatment effectiveness research. We want to find out "what works" in the practice of medicine through outcomes research, and then develop medical practice guidelines. As HCFA Administrator, I serve as Vice-Chair of the Intra-Departmental Committee for the Medical Treatment Effectiveness Program.

The true value of the effectiveness initiative lies in its potential to enhance the quality of American medicine. It will help us know that the investments we make in health care are necessary and appropriate. Given the limited resources currently available, such accountability is critical.

OTHER PRIORITIES

Improved Communication with Beneficiaries -- In addition to pursuing our cost containment and quality goals, one of my top priorities as HCFA Administrator is to make Medicare more understandable for beneficiaries.

Health care has changed a great deal in the last 25 years. Many of today's 34 million Medicare beneficiaries are frustrated by the complexities of the program brought about by these changes. Many are confused by the elaborate insurance and billing processes.

Communication with beneficiaries must be improved to ensure that the information they receive is comprehensible. This is so important that I have established a work group within HCFA to look at better ways to serve Medicare beneficiaries. I have also met with provider and beneficiary groups to enlist their support for our beneficiary communication initiative.

The work group's goals are to improve the consistency, clarity

and effectiveness of beneficiary communications. For example, the Explanation of Medicare Benefits, a form that beneficiaries receive following medical treatment, is presently under scrutiny. We need to eliminate bureaucratic jargon and technical phrases from our explanations. Further, we need to issue publications that can be easily understood by the people for whom they are written.

We are also exploring the need for more formal, on-going communication with other agencies such as SSA and the Administration on Aging. This could facilitate more comprehensive and consistent communication with the beneficiaries that we serve.

The work group is now developing specific recommendations for change, which I expect to receive within weeks. The work group will support the development of state and private-sector initiatives that conduct one-on-one counseling with beneficiaries. We hope to involve advocacy organizations and agencies in all our communication and outreach efforts. These groups, with their day-to-day contacts with older Americans, can help guide our efforts to ensure that programs and materials are pertinent and sensitive to the needs and concerns of our beneficiaries.

It is evident that a combined effort between HCFA, providers, and

groups representing the elderly is necessary to reduce the confusion experienced by our beneficiaries when they receive care. I have asked these groups to work with HCFA in a more coordinated and consistent way to educate older Americans about their Medicare benefits.

MEDICAID

I have established a separate Medicaid Bureau to give emphasis to the program which serves our neediest population -- those with incomes inadequate to obtain basic health care.

Programs to care for the poor go back the early 1900s when the Federal government began to focus on the health and welfare needs of mothers, infants, young children, and the elderly. The creation of Medicaid established a major role for the Federal government in financing health care for the poor.

Medicaid is a jointly funded, cooperative venture between the Federal and State governments. Within broad Federal guidelines, States have great discretion over who will be covered by Medicaid and the medical benefits that will be provided. Because of this, Medicaid programs vary considerably from State to State, and over time.

In its first six years, the Medicaid program grew rapidly. The creation of the Federal Supplemental Security Income program in

1974, with its direct link to Medicaid eligibility, significantly increased the number of elderly recipients. The number of Medicaid eligibles has remained fairly constant since then. In 1989, the Medicaid program paid for services provided to 23.5 million low income persons who were in certain families with children, or were pregnant, aged, disabled, or blind. From $734 million dollars in 1966, the Federal investment in Medicaid has grown to $34 billion in 1989. States committed $26 billion of their own funds in 1989 to this State-Federal partnership.

In addition to 13 mandated benefits, States can provide over 30 optional services. Budget constraints have caused many States to limit the number of optional benefits, even though the Federal government will pay from 50 to 80 percent of expenses. Medicaid program expenditures are expected to increase at an average rate of about 12 percent each year for the next five years. States tell us that Medicaid now accounts for about 11 percent of the States' budgets, and many view it as the biggest "problem" in their budgets. This is not surprising. Since the Medicaid program's inception, rapidly rising health care costs have grown faster than State revenues.

Services for Pregnant Women, Infants and Children -- Since 1984, changes to the Medicaid program have expanded the program in several ways. They have increased the number of pregnant women,

infants, and children receiving services; required States to pay Medicare premiums and copayments for poor and disabled Medicaid recipients; increased coverage of the working poor; and required quality reform in nursing homes. These and other expansions will increase Federal Medicaid costs by about $3.6 billion in FY 1991, and cause States to either reallocate resources from other programs such as education and transportation, or to raise revenues.

The need to coordinate Medicaid services with other programs for the same target groups is essential to maximizing the availability of services. In collaboration with the Maternal and Child Health Bureau of the Public Health Service, we are focusing on outreach to enroll eligible individuals and improve prenatal care.

HCFA provides matching funds to support community resources which include peer networks, churches, and community groups; home visiting "resource mothers"; 24-hour toll free hotlines; user-friendly enrollment procedures; "presumptive eligibility" for pregnant women; and shortened application forms.

Long Term Care -- About 37 percent of all Medicaid expenditures go for long term nursing home services. The quality of nursing home care paid for by Medicare and Medicaid has been a major concern for the past 20 years. Most recently, legislation has

mandated comprehensive reform of Federal regulation of nursing homes. As we move forward to implement this reform, the quality of care and quality of life will continue to improve for the residents in America's nursing homes.

HCFA has also contributed a major effort to provide information to the consumer in the Medicare/Medicaid Nursing Home Information Report. First published in December of 1987, the report details information on the population and performance of 15,000 nursing homes participating in the Medicare and Medicaid programs.

Innovative Health Services Delivery System -- In recognition of the need to assure better value for our health care dollar, we have been encouraging States to move away from costly institutional services to community-based care, and to direct recipients to more efficient, cost-effective providers of service.

States can provide home and community-based services to individuals who would otherwise be placed in an institution. These programs can cover non-medical services such as case management, personal care, homemaker services, adult day care, respite care and transportation under Medicaid. As of May 1990, 48 States are operating 279 home and community-based programs.

In recent years, States have experimented with managed care

programs to reduce unnecessary utilization of Medicaid services and achieve greater coordination and continuity of care. Currently, 28 State Medicaid programs contract with nearly 200 prepaid health plans serving approximately 2.5 million Medicaid recipients. We want to give States greater incentives to increase enrollment in managed care programs in the next fiscal year.

The Uninsured -- I am well aware that 31 million Americans do not have necessary health insurance protection. This places a burden on our health care system that is already straining under financial pressure.

This crisis is not so much one of "medical indigence" as it is "medical insurance indigence." The availability of basic, affordable health insurance is critical to any health care reform. The means of financing that insurance is equally important.

We must devise a system that adequately serves our citizens. The degree to which such a system involves Federal, State, or private-sector involvement is yet to be determined. We have already seen the Pepper Commission Report with its emphasis on employer "play or pay" participation and long term care initiatives, and we await the report of the Advisory Council on Social Security. The Departmental Task Force is working

diligently to consider all of the complex pieces of this important issue before recommending its strategy later this year.

CONCLUSION

Health care expenditures in the United States have been increasing at an uncontrollable rate, at the same time that the Federal budget has forced restraint in the growth of entitlement programs.

There are other trends that will continue to have a profound effect on the Medicare and Medicaid programs. The aging of our population, changes in morbidity and mortality, and the increased use of technological advancements in medicine over the past years have all contributed to the changing needs of the people these programs serve.

These factors have contributed to what many consider gaps in our health care system. There are diverse opinions as to what these unmet needs are, how to remedy any deficiency, and how to finance program expansions. The importance of these issues is evidenced by the number of task forces and commissions established to address these problems and recommend solutions. As we begin the second quarter century of service under Medicare and Medicaid, we all see the need to renew our commitment to those who need our help in obtaining basic health care.

These are challenging times, with difficult decisions that must be made. As we consider these tough decisions, I would again sound a note of caution. If we decide to fill insurance gaps, we must do so in a way that does not lead to overwhelming financial gaps in the future. We must make sure that we do not create incentives that contribute to unnecessary utilization and overspending. That's why potential solutions must consider the financial consequences, over the short and long term.

We are dealing with a dynamic health care system, and we are responsible for seeing that it satisfies the needs not only our of our Medicare and Medicaid populations, but of all the nation's citizens. I feel fortunate to be in a position to influence the direction an improved system will take to meet those needs.

Thank you for the opportunity to speak at this anniversary celebration. I would be pleased to answer any questions you may have.

The CHAIRMAN. Thank you, Dr. Wilensky. We will hear from the other witnesses and then come back for a round of questions.

The Chair will now recognize the next person, that is Mary Bowden. She will be represented by Mrs. Brockman. The Chair now recognizes Mrs. Brockman.

STATEMENT OF MARY BOWDEN; ACCOMPANIED BY MRS. BROCKMAN AND SHARON MCKINLEY

Ms. MCKINLEY. I'm not Mrs. Brockman. This is Mrs. Brockman. I'm Sharon McKinley, and I'm representing the family today. Mrs. Bowden is sitting to my right in the wheelchair.

On behalf of the family, we would like to thank the committee for asking us here today to speak regarding the Medicare and the Medicaid program. We are here to give the personal side of the story of how Medicare and Medicaid has affected the lives of this particular family.

I will be reading the testimony on behalf of Mary Bowden.

The CHAIRMAN. Please proceed.

Ms. MCKINLEY. [reading] My name is Mary Bowden. I am a 77 year old blind woman who has diabetes and arthritis. I live in a two-bedroom apartment with my mother, granddaughter, and great-grandson, in Maryland.

Even though I have these medical problems, I am able to do my own personal care with some supervision and assistance. I consider myself to be independent and have had education from the Lighthouse for the Blind. I have also been approved for a 3-year scholarship from their organization before moving to Maryland. I would like to pursue the services in the near future.

My mother, Merty Taylor, is 89 years old. She will be 90 years old in October. She is also blind and has diabetes, hypertension, Alzheimer's disease, and glaucoma. She requires 24 hours-a-day care in the area of bathing, dressing, feeding, and distributing medications. She is incontinent of urine and bowels; she wears extra large Depends and uses chux, which are very expensive.

My mother and I shared a senior citizen apartment in Washington, DC 5 months ago. We were receiving in-home aide services, however, the service was very poor. My mother had been left in her own excrement, and we had been without food on several occasions. As a result, my granddaughter, Mary Brockman, felt it would be best if we would move in with her—a two-bedroom apartment.

My granddaughter is 45 years old. She has a 15-year old son. She works part-time at Safeway grocery store with no benefits, including health insurance. If she misses a day of work, she does not get paid. However, if she works full-time she would not be able to give us the proper care.

My granddaughter's son has some medical problems—swollen glands, possible tonsillitis, but the exact diagnosis is unknown. She cannot afford medical care. Moreover, she is overscale for medical assistance, therefore, my great grandson goes untreated.

Before my mother and I became elderly and disabled, we worked in domestic-type jobs—housekeeper, seamstress, beautician. Howev-

er, we always made a way for our family. We never relied on anyone but the Lord to make a way for us.

Presently, we both receive Social Security. My mother receives $256.80, and I receive $266.80 and supplemental security income. My mother receives $22, and I receive $28. We also receive Medicare medical assistance. We made an appointment to apply for food stamps, but my granddaughter will have to take off to apply for us.

My granddaughter made a referral to Prince George's County, Department of Social Services, Adult Services Unit, to get assistance from their in-home aide services—The Maryland Medical Assistance Personal Care Program. However, there is a waiting list for in-home aide and, with the Maryland Medical Assistance Personal Care Program, it is hard to find a health care agency that will accept medical assistance or they state they do not have enough aides to come out to our home. Medicare will not pay for an aide to provide in-home aide services unless it is skilled medical care. So we sit and wait for service, uncertain if we will receive assistance.

A referral was also made to the Prince George's County, Department of Aging Food and Friendship Program—a home-delivered meal program. We anticipate service, but we have not received confirmation yet.

Presently, my granddaughter is paying someone privately to care for my mother and I while she is at work. However, it is very expensive and, as a result, she has unmet bills because she must pay someone to care for us. The rent is $695 a month. Our checks used to be enough to help with the rent, but now our checks are decreasing because Medicare premium is increasing. Therefore, less income is available for household expenses.

I am aware that we could go to a nursing home, however, we would not receive the love and the personalized care. My granddaughter feels, and I quote, "If the shoe was on the other foot, she would not want to be placed in a nursing home." Therefore, she is doing everything within her power to make our final days comfortable. In addition, it is more expensive, and some nursing homes are being threatened to be closed because of the improper care and sanitation problems. So community services are a must in order to keep elderly people like my mother and I at home and in a safe and loving environment.

In closing, I would like to say that the elderly population is growing every year due to advanced medical technology. Therefore, community services should also grow. You all should not forget the elderly. We are your past and your future. Without us, you all would not be here now.

So the services we need such as medical assistance and Medicare could, and should, be provided in the community if they are made and designed to do what they are supposed to do, which is to provide community services to prevent placement in an expensive institution.

Thank you.

The CHAIRMAN. Thank you, Ms. McKinley.

The third witness is a gentleman that we all know very well. We know him because he is an extremely well-known actor who has starred in many films. One of his latest and most acclaimed was

"Atlantic City," an excellent film. He comes before this committee as a person that is committed to helping those Americans who live without health and long-term care protection.

Today, he also comes to us as a representative of a deeply concerned organization, the Screen Actors Guild, many of whose members have no health insurance.

The Chair now is pleased to recognize Mr. Burt Lancaster.

STATEMENT OF BURT LANCASTER

Mr. LANCASTER. In "Atlantic City," I was an old man, but I managed to pay my own medical bills.

Chairman Roybal, members of the House Select Committee on Aging, thank you for giving me the opportunity to appear before you today.

Twenty-five years ago, the United States adopted the Medicare and Medicaid programs to deal with the growing health care crisis for the elderly, the disabled, and the poor.

Over the ensuing 25 years, these two plans have gone a long way toward meeting the needs of millions of Americans who qualify for help under these programs. This is what we have gathered here to celebrate—a bittersweet celebration—for as we have just witnessed there is still an enormous amount left to do.

As we sit here, more than 50 million of our fellow citizens are either uninsured or underinsured—50 million men, women, and children who have little or no access to the health care system. Of these 50 million, 37 million have no insurance at all. They are not the very poor or the elderly. Thanks to Medicaid and Medicare, these two groups have at least some coverage. No, the vast majority of the uninsured are working Americans and their children, over 70 percent of them earning income above the poverty line. Any illness in these peoples' lives quickly becomes catastrophic.

Just about every family in America eventually faces a long-term care crisis—a husband who has been hit by a stroke, a wife with a broken hip, a child with cerebral palsy, a grandfather with that new kid on the block, Alzheimer's disease, arguably the most devastating of all.

It's not just the personal anguish that devastates the family. It's also the crushing financial burden they face. Nursing homes cost, on an average, $30,000 and up a year. Families who try to provide care in their own home, it often means tens of thousands of dollars in lost income. When tragedies like this strike, a family's whole world can collapse.

Enormous inflation in the costs of health care has caused many employer/employee insurance plans to be discontinued or greatly curtailed. For example, in my own union, the Screen Actors Guild, we faced a severe crisis in 1988 when we were hit with a devastating increase in our insurance premiums. In order to maintain a solvent plan for some of our members, we were forced to drop over one-sixth of the eligible members from the plan. That's nearly 5,000 people potentially joining the ranks of the uninsured.

What happens to people without health insurance in this country? They're afraid. Many put off needed health care because they know they can't afford it. Many of those who do seek help are

turned away from private hospitals and clinics and dumped onto the county systems which cannot handle their existing patient loads. Even this particular solution is hardly effective, since only one out of every three facilities, in order to avoid having to treat the uninsured, have closed their emergency rooms and trauma centers.

These hospitals and clinics, which to accept the uninsured and the underinsured, must cover their losses by charging more to those with the ability to pay. This further drives up the costs of health care, which are passed along to the rest of us through higher insurance premiums or reductions in covered services. Obviously, the numbers of uninsured and underinsured in this country are a problem for all of us.

The United States, still the richest Nation on Earth, I hope, must find a way to provide all of its people with universal, comprehensive health care. Simply put, it's the right thing to do because we cannot afford not to do it. Today, we have a system which cannot provide prenatal care to a teenage mother at a cost of a few hundred dollars, but will take care of her premature infant for months at a cost of $100,000. I submit to you that the system is just not working.

Twenty-five years ago, through the Medicare and Medicaid programs, this country made a commitment to the elderly, the disabled, and the poor. Today, we at the Screen Actors Guild believe we must make that commitment to all Americans by guaranteeing them a national health plan.

America has always prided itself on being a great Nation. Today, it truly stands as a model for the rest of the world. For it to fail to provide a national health plan to all of its citizens is simply intolerable.

Thank you, Mr. Chairman, ladies and gentlemen. Thank you for your kind attention.

[Supplemental material submitted by Mr. Lancaster follows:]

SCREEN ACTORS GUILD

FOR IMMEDIATE RELEASE:
May 16, 1990

CONTACT: MARK LOCHER
(213) 856-6650

SAG BOARD ENDORSES NATIONAL HEALTH PLAN

The National Board of Directors of the Screen Actors Guild has unanimously endorsed the implementation of a national health care plan in the United States. Health care has become a primary concern of SAG performers since eligibility for the SAG-Producers Health Plan increased to $5,000 a year on January 1, 1990, leaving only about one-third of Guild members with SAG medical insurance.

On May 15, by a vote of 67 to 0, the SAG National Board adopted the following resolution:

WHEREAS health care is a primary concern of every human being, and

WHEREAS health care costs are increasing steadily with no indication of any reversal, and

WHEREAS health care insurance premiums have risen so dramatically that many persons find it impossible to pay, and

WHEREAS over 37 million Americans have no health insurance protection at all and another 53 million are inadequately insured against catastrophic illness, and

WHEREAS such uninsured and underinsured persons cannot do without health care and, as a result, obtain it in emergency rooms or other facilities which shift this cost by raising rates for those who are insured, and

WHEREAS less than half of the Screen Actors Guild membership has qualified for coverage by the SAG-Producers Health Plan, and

WHEREAS the United States and South Africa are the only two industrialized nations in the world which have failed to provide a guaranteed standard of health care to all citizens, and

WHEREAS all Americans suffer from this failure physically, mentally or financially,

THEREFORE BE IT RESOLVED that Screen Actors Guild endorses the prompt adoption of a National Health Care Program which provides the following:

* A guaranteed, comprehensive and universal system of health care available to everyone, regardless of ability to pay.

* Free choice of physicians, therapists, hospitals or clinics.

* Mandatory cost-containment mechanisms.

FURTHER, the Guild encourages its members to speak out publicly and work actively to bring about such a program.

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The CHAIRMAN. Thank you very much, Mr. Lancaster. Our final witness is a well-known and dear friend to me and to the committee. He is a die-hard supporter of Medicare and Medicaid. Fortunately, for millions of Americans, his efforts do not stop there. His caring and nonstop effort to bring about national health care reform that would result in universal health and long-term care protection for all Americans is a source of great inspiration to this committee and to many of us.

The Chair now recognizes Dr. Arthur Flemming.

STATEMENT OF ARTHUR S. FLEMMING

Dr. FLEMMING. Thank you, Mr. Chairman. It is an honor to participate in this hearing marking the 25th anniversary of Medicare and Medicaid.

I appreciate especially, Mr. Chairman, your invitation to me to recall the past and then relate it to the present and the future. Many of us are deeply appreciative of the fact that the approach reflected in your invitation is a clear reflection of your leadership as chairman of this committee and your leadership in the House of Representatives.

You honor and respect what has been done, but you are always pushing for the actions that will respond to today's and tomorrow's needs.

As Secretary of Health, Education, and Welfare, I was assigned responsibility by President Eisenhower for organizing and conducting the first White House conference on aging which was held early in January 1961. On this Sunday prior to the opening session, an interfaith service was held at the Washington Cathedral. A very moving message entitled, "To Grow in Wisdom" was delivered at this service by one of the 20th century's great prophets, the late Abraham Heschel, who was then professor of Jewish ethics and mysticism at the Jewish Theological Seminary of America.

In the course of his address, Professor Heschel said, "By what standards do we measure culture? It is customary to evaluate a Nation by the magnitude of its scientific contributions or the quality of its artistic achievements. However, the true standard by which to gauge a culture is the extent to which reverence, compassion, justice are to be found in the daily lives of a whole people, not only in the acts of isolated individuals. Culture is a style of living compatible with the grandeur of being human.

"This is one of the great Biblical insights: the needs of suffering humanity are a matter of personal, as well as public, responsibility. The representatives of the community are held responsible for the neglect of human life, if they have failed to provide properly for those in need. The ancient sages realized that it was not enough to rely upon individual benevolence, and that care for the sick was a responsibility of the community.

"It is in accord with this tradition that all major religious organizations have endorsed the principle of government responsibility and the use of the Social Security mechanism as the most effective medium for dealing with the problem of medical care for the aged." That was in January 1961.

Before the end of that week it became clear that a large percentage of the delegates to the first White House conference on aging concurred in Rabbi Heschel's moral judgment that the national community should accept responsibility for making sure that there was an adequate response to the health care needs of the elderly.

As Secretary of HEW, I had dealt with the issue of health care for the aged prior to the convening of the White House conference on aging. President Eisenhower had personally requested me in a conference in the oval office to work with my associates in the development of a plan which he could submit to Congress to expand our Social Security system in order to meet the health care needs of older persons. We accepted that assignment with enthusiasm.

After he expressed his support for this approach at a press conference in response to a question, President Eisenhower was reminded that in a campaign address in 1952 he had said that he would not recommend expanding the Social Security system in order to meet the health care needs of the elderly.

He then told me that he was going to continue to adhere to his policy of acting or not acting in a manner consistent with promises made during his presidential campaigns. He instructed me, however, to provide him with a liberal Federal/State plan that would be financed out of general revenues. I won't take the time to describe it, but we did present a very liberal plan, one that went over into the area, care of eyes, teeth, prescription drug, and so on. This was done, as I indicate, but not accepted by the Congress.

Early in the 1960s, after a proposed Medicare plan had been rejected twice by the United States Senate, I agreed to head a commission made up of persons from outside of Government to take a fresh look at the issue of health care for the elderly. At that time, I was serving as president of the University of Oregon.

This group was established by Senators Anderson and Javits, after consultation with President Kennedy. Our report, submitted to President Kennedy 1 week before his assassination, played a role in establishing Part B of Medicare, breaking the impasse, and bringing about the passage of Medicare in 1965.

I will never forget that conference with the late President Kennedy. I was the last to leave the oval office. He stopped me and wanted to know if I was going to testify in behalf of the plan that we had submitted. I said, "Of course I would." I'd worked on it for over a year and a half with my colleagues. He then shared with me his feeling of frustration over the fact that, during the Presidential campaign of 1960, he had vigorously espoused the idea of Medicare for older persons, but he felt very frustrated over the fact that the Senate had twice rejected that plan.

But at long last, in 1965, the national community had recognized its moral obligation to respond to the needs of the elderly ill. At the same time, as a result of the passage of Medicaid, the national community placed itself in a position to respond more effectively to the medical needs of the medically indigent of all ages.

All of us rejoice in the fact that millions of older and disabled persons have been the beneficiaries of the actions taken 25 years ago. Personally, I appreciate, Mr. Chairman, that you and your colleagues have issued a report today summarizing those benefits.

At the same time, as you have pointed out, we recognize that as a result of our patchwork health car system, our national community is not living up to the standards of reverence, compassion, and justice in the care of the sick of all ages that was lifted up by Abraham Heschel at the first White House conference on aging.

What can we do to correct a situation which, if left uncorrected, will continue to undermine the ability of millions of our people to achieve their highest possibilities?

You, Mr. Chairman, over a span of years have provided a specific, well thought through, U.S. Health Act, now included in H.R. 2980, which would provide us with a nationwide program that would build on our experiences with Medicare and would cover acute and long-term care.

Claude Pepper believed, as you do, that the vast majority of the people of our Nation support universal right of access to health care, including long-term care. He was deeply disturbed over the fact that this all-important issue was not on our Nation's political agenda.

That is why he persuaded the Congress to create a Commission of 12 congressional health policy leaders and three administration appointees charged with recommending Federal policies and programs that would make it possible for all persons living in the United States to have access to comprehensive health care.

As he said time and again, he wasn't calling for another study commission but for a commission that would produce a plan of action for consideration by the Congress.

Early in March of this year, the Pepper Commission, under the chairmanship of Senator Rockefeller, made recommendations to the Congress which add up to an action plan that, if enacted into law, would give us a national health plan that would provide universal right of access to health care, would constitute a giant forward step in the area of long-term care, and would provide a start on cost containment. Personally, I appreciate very much Senator Rockefeller's testimony today giving further light on those recommendations.

The Pepper Commission, it seems to me, has done what Claude Pepper wanted to have done. Namely, it has put the issue of universal right of access to health care on the national political agenda. The recommendations of the Commission build on the foundation laid by Medicaid and Medicare.

The recommendations for universal access include provisions for a public plan which would draw on our experiences under Medicaid but which would provide for Federal financing and administration. At the heart of the recommendations for long-term care is a recommendation for social insurance for home and community-based care. In other words, a recommendation for the expansion of Medicare to cover all age groups and to narrow the existing wide gaps in long-term care.

The Pepper Commission recommendations, however, are the start, not the end, of what can prove to be an historic development in this 50-year battle. The next step in the process must be in-depth hearings by the appropriate committees of the House and the Senate on the Pepper Commission action plan.

Conflicting testimony will be given as to the best method to follow in order to achieve the Pepper Commission goals. The committees will have to weigh the evidence and resolve the conflicts when they mark up the bills.

Yes, it is imperative for us to keep health care for all on our political agenda until we get action—action which includes a plan for funding.

A summit conference is now underway in Washington in connection with the Nation's overall fiscal policies, which could have a profound impact on people programs for years to come. We must make sure that the financing of a national health plan is a part of any agreed-upon package.

If recommendations such as those made by the Pepper Commission were phased in over a 5- or 6-year period, it would mean that in the fifth or sixth year our expenditures would have increased by $62 billion a year—a 10 percent increase over our present total bill of $600 billion, expenditures by both the private and public sector.

But let's remember that if we continue to drift over the next 5 years with our present patchwork system, including an inadequate cost containment program, our costs will have escalated far beyond 10 percent, and we will still have a patchwork system. The cost of a national health plan must be a part of any 5-year fiscal program for our Nation.

But, let's face it, the process started by the Pepper Commission could come to a grinding halt. Committee hearings could be delayed and delayed. Mark-up of legislation by the appropriate committees could be delayed and delayed. Costs of a national health plan could be omitted from the Nation's 5-year fiscal plan. This would be a tragedy.

Today, our patchwork health care system is leading to hundreds of thousands of premature deaths—is resulting, for example, in an infant mortality rate which is a national disgrace. Today, our patchwork health care system results in millions undergoing unnecessary suffering. Today, our patchwork health system with its spiraling costs is placing an intolerable financial burden on the backs of millions of our people. Now is the time for action.

The polls and other relevant evidence show that millions from all segments of our society believe that the time for rhetoric in the health care field is over, and the time for action has arrived. Many of us are urging those who have this conviction to urge the Members of Congress, and especially the members of appropriate committees, to hold in-depth hearings in Washington and out in the country on the Pepper Commission recommendations.

We are saying to them, "If you favor some other methods for achieving the goals the Pepper Commission was charged with achieving, submit your views to the committees personally or through organizations to which you belong. But tell them that you want the process started when they created the Pepper Commission and which has been moved forward in such a significant manner by the members of the Commission to continue, and to be accelerated, and not to be sidetracked."

The Congress, through the Pepper Commission, has provided us with a light at the end of a long tunnel we have been traveling in order to achieve the goal of health care for all. If we pursue our

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opportunity with the same persistence and the same dedication that characterized my friend, the late Wilbur Cohen's pursuit of the Medicare objective, we can and we will move forward.

I believe we will succeed because our cause is right. It is right because, again, as Abraham Heschel told us back in 1961, "It is a cause rooted in one of the great Biblical insights: the needs of suffering humanity are a matter of personal, as well as public responsibility" and that care for the sick is a responsibility of the community.

Thank you, Mr. Chairman.

The CHAIRMAN. Dr. Flemming, I'd like to thank you for a unique historical perspective and background on Medicare and for pointing to us the direction that we must go if we must meet that public responsibility to the sick.

The committee will now go into a so-called 5-minute rule. Each member of the committee will be recognized for 5 minutes. I will try to hold that to exactly 5 minutes and no more. So it's 5 minutes or less.

I will now recognize, first, Ms. Morella.

Ms. MORELLA. I thank you, Mr. Chairman.

I ask unanimous consent that my opening statement might be included in the record.

The CHAIRMAN. That has been done.

Ms. MORELLA. Thank you. I also appreciate the courtesy that you just extended to me because I'm going to handle a bill on the floor eminently.

I want to thank the panel also for their very dramatic and sincere testimony on behalf of proper health care for all Americans, adequate and for those who are not insured.

I wanted to ask specifically Dr. Wilensky a question that has to do with a Supreme Court decision in terms of what its impact may well be for the States in terms of the Medicaid program. That's the one that was Wilder v. The Virginia Hospital Association.

Dr. WILENSKY. We believe that the impact may not be as dramatic as was indicated in the newspapers a few weeks ago because it is basically reaffirming what had been occurring. The big difference that will occur now is that the associations will have the right to have their cases heard in Federal court, whereas previously it had sometimes only been heard in the State court. It is possible that the Federal court will be more sympathetic in the challenges of the associations than the State court has been.

There have been a number of challenges that have been made and that are currently in process. To the extent that the States are ruled against and found to have rates that are not adequate and necessary, it will obviously cost the States that are ruled against, as well as the Federal Government, additional dollars, but this decision was primarily to indicate the right of a hearing in the Federal system.

Ms. MORELLA. I'm really glad to hear that because it seemed to me it could have some very adverse affects.

One final question to you has to do with what I had heard through the committee staff, and I guess it's been reported that one-fourth of the applicants for Medicaid have real problems with

the questionnaire and, therefore, are not part of the program. Have you been doing something to try to reach those people?

Dr. WILENSKY. We are interested in trying to simplify the forms. There have been some attempts by various States to do this, particularly through some of the presumptive eligibility clauses for pregnant women.

We are anxious to work with the States in trying to make this process a simpler one. Medicaid is an area in which the States themselves set many of the specific rules within very general Federal guidelines. And so, while we have some ability to simplify the process, at least under current statute and regulations, substantial discretion is left to the States.

Ms. MORELLA. Mr. Lancaster, how come you happened to be chosen to represent the Screen Actors Guild?

Mr. LANCASTER. Well, because I'm a member of the Screen Actors Guild.

Ms. MORELLA. What kind of program do they have? Is it a management care program?

Mr. LANCASTER. Well, the program that they have that would relate to what we're discussing today is their insurance policy. You see, members of the organization have to earn a certain amount of money in the year in order to qualify for the plan, which is a very fine one, but the union is still a relatively small one. Contrary to what many people think, there aren't that many actors in the world. The people simply have to make a certain amount of money, and it's not a great deal really, except to them, in order to qualify for this plan.

A year and a half ago, I believe it was, we had to drop 5,000 members, who simply couldn't make enough money during the year in order to be allowed to enter the plan and be recipients of it.

Ms. MORELLA. And so the Screen Actors Guild has included, I noticed in your testimony, the resolution—

Mr. LANCASTER. I'm sorry. What?

Ms. MORELLA. You have included in your testimony a resolution by the Screen Actors Guild for a national medical plan—

Mr. LANCASTER. Well, we think something should be done about insurance which will allow the whole county to, as it were, to be able to meet the demands of that insurance, a national health plan that would not permit a crisis of this kind to arise again.

You realize, of course, that South Africa and the United States are the only two industrial countries in the world who do not have health insurance. I mean, it is, as my good friend on the left here, the doctor, was explaining so beautifully, it is something that is due, and it is inherent in any organization, any county, any government, if you will, to take care of its people. It is the purpose for having a government, unless you want to include something like dictatorship or something of that nature.

Any kind of a bona fide republic or democratic system has to meet the demands of its people. It has to be both an inspiration to them, and it has to be able to help them in their times of crisis.

One of the things that it has to ensure is the health of its people. In order to do that, it has to have a health plan that includes every body. I laugh when I come back from places like Italy which, right after the war, was so devastated, who now have a health plan that

would stand you on end. If I'm a servant in an Italian house, for instance, and I work there for say 25 years, it's not uncommon for me to get $100,000 as a payoff, and my health plan is paid for all during the time I'm there. All during the time I'm living in that country as a citizen of that country, everything to do with health is taken care of.

Now a lot of people may not like the idea. They may feel that it legislates against their own needs. But the important need is that people as a whole, the body politic of the country, the citizens of the country, they have to. No country can hold its head up who doesn't say, "Wait a minute. I must take care of my children," if you want to put it on those terms.

Ms. MORELLA. Well, I think this committee probably fully agrees with you and certainly the panel that we have just heard—you are all in accord with what you have stated in terms of the purpose of a country to make sure that the health of its citizenry is attended to.

Mr. LANCASTER. Of course.

Ms. MORELLA. I want to thank the panel, and I want to thank you, Mr. Chairman. I know you want to get on with other people.

The CHAIRMAN. All right. Thank you.

The Chair now recognizes Mary Rose Oakar.

Ms. OAKAR. Thank you. Mr. Chairman, I think the plight of the grandmother, Mary Bowden, whose representative did a fine job, mirrors what's happening in this country, not only to the elderly but to so many of our citizens, at least 75 million of them who are underinsured.

I have to say publicly that I am saddened that Dr. Sullivan, on behalf of the administration, has gone on record opposing universal coverage. During the proceedings of the Pepper Commission, members were lobbied by the White House not to even support the plan that we came up with in a consensus 8 to 7 vote. We've seen Medicare devastated over a period of 7 years in cuts.

My own State of Ohio is fighting HCFA to keep alive its Medicaid care assurance program. I mean, when does it end? So I really have to tell you, Dr. Wilensky, I'm not pleased with the administration's position in being an advocate because I don't think they're an advocate. It's not a partisan way of saying it because Dr. Flemming pointed out that the first seeds of Medicare, et cetera, were during the Eisenhower administration, and then during the course of things, Kennedy, and finally during the Johnson administration we did see that this was a bipartisan national need.

Mr. Lancaster, I want to say I think you're eloquent as a representative of your union. I think you're one of the most fabulous actors in the world. I'm not ashamed to say I'm a fan of yours, and I want your autograph, if I can get it.

Mr. LANCASTER. My health is not so good now. I make a lot of trouble getting a job.

Ms. OAKAR. Well, I don't think you will, judging by your many films and your artistic achievements.

Mr. LANCASTER. Thank you very much. The last picture was a problem, and we have to deal with it.

Ms. OAKAR. Let me just say this: I think it is fitting—and this is what my point was really—that you come on behalf of the Screen

Actors Guild because, in fact, the AFL-CIO is on record, in terms of endorsing the concept of universal health insurance.

Frankly, artists do heighten the awareness of the American public because, let's be honest about it, when Angie Dickinson comes before this committee and talks about diseases affecting her sister who is elderly, or George Burns talked about age discrimination and not wanting any part of that, we do get a momentum because the American people do sort of follow you people, and that's probably why some of the cameras are here today—to let the American people know what we're all about.

So I'm delighted that you are speaking on behalf of your union—a very viable union.

Mr. LANCASTER. Well, I really speak on behalf of all America because I think that's what this country should enjoy.

Ms. OAKAR. Well, I do, too. Dr. Flemming, as you know, I've introduced a bill related to universal health coverage and so on. I want to get to the cost because everybody says that it costs too much. Even my distinguished chairman of the Pepper Commission mentioned that, if we have it, 5 or 6 years down the road it's going to cost $285 billion.

I wonder if you know, Dr. Flemming, or any one of the panel knows, how much Americans are already paying for health care in this country because we pay more than any other country and get a lot less? Does anybody know what the price tag is for health care in this country today? Doctor, do you know?

Dr. WILENSKY. About $600 billion.

Ms. OAKAR. It's about $600 billion? I'd add about $61 billion onto that. So we pay $661 billion. When people ask, "How do we pay for it," we're already paying for it. Americans spend $200 billion in private insurance, $90 billion for Medicaid, and the rest is for other Government programs.

Dr. Flemming, do you know how much the average person pays in out-of-pocket expenses?

Dr. FLEMMING. I don't have the figure in my mind, but I know that the beneficiary under Medicare today is paying more in out-of-pocket expenses than people 65 and above were paying before Medicare was passed. That keeps going up.

I think, in your report, you do have that figure. I—

Ms. OAKAR. It's about $1,900 a year in out-of-pocket expenses, more than Canada pays per person for comprehensive coverage, including long-term care.

Mr. LANCASTER. Well, what does that mean? When you tell me that Canada pays so little comparatively speaking, and manages to still fulfill a program, what does that say to you? Does it not say to you and to me that there is something wrong with the cost of medical coverage? In other words, what's wrong in our country that makes it necessary to spend that kind of money?

I am a heart patient. My heart bills are astronomical. I mean, I could afford to pay them but, believe me, I would really have to be working all the time. Now there has to be some way that the country, in light of what the doctor here was talking before when he said about the rabbi saying the responsibility to themselves and to the people, is the first—it's like the beginning, the ABC, of what human treatment to your fellow man ought to be.

So, consequently, you have to say, "Wait a minute. Who is making all of this money? Why are they making all of this money? Why are all these enormous profits—because there must be tremendous profits in it—where are they coming from? Why are our countries saddled with them?" So that, consequently, when you fall a little below the insurance rate, you're out of the ballpark.

Now you say, "Well, this is not what we're talking about." I beg your pardon. This is exactly what we are talking about.

Ms. OAKAR. Well, I agree. Let me just conclude by saying this: when you have a single payer, like a Government policy, pay for insurance you save in 1 year, $24 billion. When you deal with prevention over a 3-year period, which we try to do by setting not only coverage but a high standard, you save another $45 billion. You save money and save lives. We're not doing that in this country, and we can do a lot better.

Thank you all for appearing here.

The CHAIRMAN. Thank you very much.

The Chair will now recognize Mr. Downey.

Mr. DOWNEY. Thank you, Mr. Chairman.

With the admonition in mind that Mr. Lancaster gave us, that we should stay on the subject, let me just say that I've always liked his politics, and I enjoy them even more after hearing him eloquently address what I consider to be one of the more important issues that we face.

I want to ask you, Dr. Wilensky, some questions about the waiver process and also whether or not the Under Secretary's Task Force will provide some comprehensive proposals on long-term care for the unemployed. Do you anticipate that that would be part of the task force agenda?

Dr. WILENSKY. Yes. The Under Secretary's Task Force is currently at work. We will be making recommendations and having discussions within the Department. There has been already, as a result of the State of the Union message, a Domestic Policy Council formed that Secretary Sullivan is leading. This is similar to the dual process where there is activity going on within the Department to outline both principles, options, and some preferred strategies and, at the same time, in a parallel fashion, activity going on within the Domestic Policy Council.

It is my belief that sometime before the end of the year, both within the Department and probably within the Domestic Policy Council, although that activity is proceeding at a parallel step, but somewhat behind since it was formed later, that there will be some recommendations emanating out of that activity.

Mr. DOWNEY. Before the end of the year?

Dr. WILENSKY. Yes.

Mr. DOWNEY. Oregon has a much discussed policy of trying to determine what they are going to finance and what they aren't going to finance under Medicare and Medicaid. That will apparently require a waiver from your office.

Dr. WILENSKY. That's correct.

Mr. DOWNEY. I've had the opportunity to take my subcommittee down to Florida. It really appears to me that a lot of the community-based care programs, if properly funded, and if eligible for Medicaid waivers, could save a fortune in terms of keeping people in

their homes where they would prefer to be as opposed to being put in nursing homes where they wind up.

Can you give me some idea of how you feel about this waiver process and possibly going beyond making these programs eligible for Medicaid funding so that we can keep people from nursing homes and long-term care facilities?

Dr. WILENSKY. You've raised two or three separate questions. Let me try to address them quickly. Medicaid currently has a process under a home and community-based waiver program whereby a State can request a waiver if it can demonstrate that the program it would like to put in effect would indeed be cost effective in terms of keeping people out of nursing homes. There are a substantial number of States that have such programs.

Mr. DOWNEY. Do you know off hand which States have such programs?

Dr. WILENSKY. The State of Washington has one. Some of them have them very successfully. The State of Wisconsin has one.

Mr. DOWNEY. These are State-based programs? Or are they just programs in counties?

Dr. WILENSKY. There are some 48 States that have various kinds of waivers. I believe that they can be both statewide and they can be specific, depending on how the request comes in for the waiver. The State of Washington, for example, is a statewide program.

There has been some concern about the waiver process being an unnecessarily cumbersome one. I have asked a group to look at this. I think it's very important for HCFA to try to be flexible and help States do what they wish to do. We are going to try to see whether we can't be more responsive to the States.

Mr. DOWNEY. Well, that's excellent because I think that—I mean, I can only speak for myself—but the hearing we held, the subcommittee held, was in Pinellas County and Representatives Bilirakis and Young were there. This is a bipartisan concern, that this process of saving money and also making sure that people spend as much time as they can in their homes as opposed to long-term care facilities is something we want to facilitate.

Let me ask you about the personal needs allowance under Medicaid. It was $25 in 1973. It is $30 in 1990. If inflation were taken into account, this would be a $100 figure. Is there any view in your agency or in the Department to increase the personal needs allowance somewhat?

Dr. WILENSKY. The figure that you just cited is the minimum figure, and it's an amount that is set by the States and certainly can be set, and one could argue should be set, much higher.

Mr. DOWNEY. Let me ask you one final question. Congressman Stark and I have proposed in the Ways and Means Committee a proposal to provide an additional 26 weeks of unemployment insurance coverage to people who are put out of work by virtue of Federal action. This would be people unemployed as a result of base closings, defense plant closing, people who may be unemployed as a result of the Endangered Species Act, or the Clean Air Act. I realize I'm hitting you cold, and I don't expect a knowledgeable answer, but I would like you to think about this.

We propose to pay this additional 26 weeks, up to 52 weeks total, and we propose further that people who would be eligible under

this program also be eligible for Medicare, that they would pay a fee for Medicare. I'd appreciate it if you'd take a look at that. We're going to have a hearing on it on Wednesday. It's my hope that we will pass something like this at least out of the House before the end of the year. I certainly want to have your view of how this would impact HCFA and the Medicare program in particular.

Dr. WILENSKY. I would be pleased to submit a response for the record.

[The following material was subsequently supplied for the hearing record:]

STATEMENT FOR THE RECORD

LOUIS B. HAYS

ASSOCIATE ADMINISTRATOR FOR OPERATIONS

HEALTH CARE FINANCING ADMINISTRATION

FOR THE

WAYS AND MEANS COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

August 1, 1990

The Health Care Financing Administration is pleased to have this opportunity to address the Downey-Stark Amendment to provide cash and health insurance benefits to dislocated workers.

While we recognize the concern that these Subcommittees have for the important issue of health care for dislocated American workers, the Department of Health and Human Services is opposed to this particular proposal. We do not believe that the Medicare program is the appropriate means for providing health care to dislocated workers and their families.

Medicare is an insurance program. It is not designed to provide short-term medical assistance to unemployed individuals and their families. Covering short-term health benefits through an unemployment system would be a major change in the mission and the operation of Medicare.

Medicare eligibility is tied to Social Security eligibility, which is based on covered employment. The proposal would expand Medicare to cover an entirely new group of beneficiaries. This would create a harmful precedent by adding a group of beneficiaries who would qualify under new terms that are completely inconsistent with the purpose of the Medicare program.

Based on our best understanding of the proposal, we believe the provision would seriously burden the operation of the Medicare program, and is likely to have a significant impact on the Social Security Administration, which currently handles the enrollment process. In fact, we estimate it could take 18-24 months to put in place the systems, instructions and procedures necessary to operate this program for dislocated workers.

The proposal raises considerable enrollment and disenrollment concerns for the Health Care Financing Administration. Medicare is based on individual enrollment and does not accommodate or differentiate information about families. Information processing and data collection for health insurance utilization records are set up for individuals. The enrollment process for this new population of beneficiaries would be more complicated than the present enrollment process.

While enrollment issues would be serious barriers to this proposal, the most significant administrative obstacle would be frequent disenrollment from the Medicare program. There are generally three ways that a person is disenrolled from Medicare. Most frequently, a beneficiary is disenrolled following death. Some beneficiaries withdraw their Medicare benefits voluntarily each year, and some have benefits terminated due to unpaid premiums.

None of these processes involves a pre-defined period of coverage and an expiration date. Today, Medicare beneficiaries are almost always enrolled for permanent benefits. Under the Downey-Stark proposal, Medicare eligibility for a dislocated worker and family would end when the dislocated worker found a new job or after 6 months of coverage, whichever came sooner. This would require SSA and HCFA to continually track eligibility to provide benefits and collect premiums for only the appropriate period. We would need to develop an elaborate new system of short-term eligibility verification. Presently there exists no structure in the Medicare program that would track beneficiaries' and their families' eligibility over time.

Another obstacle to implementing this proposal would be the need to coordinate Medicare benefits with other insurance. The provision is designed so that Medicare would remain the secondary payer, except to COBRA-extension coverage of the worker. Identifying additional health care coverage available through the spouse of a dislocated worker would be a complication that would occur quite frequently in this population. You have seen the difficulty we have with Medicare Secondary Payer situations with our current, stable beneficiary population. It would be infinitely more complicated to coordinate benefits under this proposal.

It would also be complex to arrange for payment of the Medicare premiums. The Downey-Stark proposal suggests that premiums for

dislocated workers and their families would be collected through a deduction in unemployment insurance benefits. But coordinating premium payments from 54 different State unemployment programs would be cumbersome as well as costly.

We are concerned that we would need to make a myriad of technical payment adjustments to accommodate this new population of beneficiaries. And because this proposal will not incorporate managed care systems, these beneficiaries would not be able to take advantage of the more cost-effective means of care delivery that we are encouraging in the Medicare program.

It is difficult to know the magnitude of the costs associated with implementing this proposal. The numbers of people that would become eligible for Medicare benefits under this proposal are unclear. Actuarial estimates of these populations are necessary to calculate the financial impact of the proposal and the amount the unemployment trust funds would need to supplement the Medicare trust funds.

As we concentrate on reducing Federal expenditures it is clear that expanding the Medicare program is not the best way to meet the needs of workers dislocated due to changes in federal policies. Thank-you for the opportunity to submit this statement.

Mr. DOWNEY. Secretary Dole has already said that the President is going to veto it, so my guess is there is probably not a lot of room here, but we would like you to take a look at what its impact would be in particular on the Medicare program because that is our concern that—if you're out of work for that time, as you know, the first 26 weeks are covered under COBRA, but the final 26 weeks, if we extend these benefits, need to be picked up so people will have some transitional benefits during periods of unemployment.

The CHAIRMAN. All right. The time of the gentleman has expired.

Mr. DOWNEY. Thank you, Mr. Chairman.

The CHAIRMAN. The Chair recognizes Mr. Kennedy.

Mr. KENNEDY. Thank you, Mr. Chairman.

First of all, let me say, Mr. Chairman, how appropriate it is that you have these hearings at a time when the 25th anniversary of the signing of Medicare and Medicaid is being celebrated by the people of our country. But it's also a time when I think most of the senior citizens, in fact probably all senior citizens, and most of the rest of us are recognizing that seniors are really no better off today than they were 25 years ago when this program was put into place. As a matter of fact, as you probably stated before I was able to attend the hearing, that in terms of the total cost of health care coming out of a senior's pocket, it is about the same today as it was when those programs were first implemented.

So, in fact, with all the billions and billions of dollars this country is spending on Medicare and Medicaid, our senior citizens are really not a heck of a lot better off than they were back in 1965 when Dr. Flemming and others were working on implementing this program.

I wondered specifically, Dr. Wilensky, you mentioned in Tom Downey's question that you are conducting some analysis that indicated if a State can provide you with information stating they are cost effective at keeping people out of nursing homes that you allow them waivers. It just seems to me that if you look at visiting nurses and their capability to go into people's homes, and recognize that right now, the Federal Government only provides for acute short-term needs after an operation, and that's the only circumstances that we'll pay for an elderly person to receive long-term care at home.

Doesn't it just make sense to you to extend that to chronic care and recognize that that is the lion's share of what our Nation's elderly need? Can't we, in fact, do something better that is going to avoid the cost of nursing homes, and rest homes, and the like, and keep people where they want to be—in their own homes?

Dr. WILENSKY. There's no question that people prefer to be kept in their own homes, and there is substantial interest in trying to assist that. However, contrary to what some people are aware of, the ability to target people for home care who would otherwise go into a nursing home, has been much more difficult than we might presume.

There was a series of studies done in the early and mid 1980s by a number of research groups throughout the country that have indeed found that to the extent that you target those who would

otherwise be in a nursing home, you save money with home care. Our inability to pick that target very well means that we usually end up spending more money.

Now that is not to say—

Mr. KENNEDY. I don't question that you might—if you do a study that says that all you're going to look at is the individuals that are currently in nursing homes and say, "Well, if we provided them would home care, would they have been able to stay at home," and you might not find that that is necessarily going to yield you a tremendous amount of additional dollars to the system.

But, on the other hand, what you might find is that individuals might never have gone into those nursing homes if, in fact, they had been provided with health care at home. It doesn't make sense.

Dr. WILENSKY. Well, it was not done by bureaucrats. It was done by research organizations at universities. It's not to say you shouldn't do that.

Mr. KENNEDY. Well, I don't care whether a bureaucrat works for a State organization—a university or the Federal Government, you know.

Dr. WILENSKY. It's not to say that you should or should not cover the service. It's to say, if you're going to do it on the argument that you're going to save money, thus far at least our ability to target those services has not shown them to have great ability to save money. You may wish to do it for other reasons.

Mr. KENNEDY. I think that what you're really doing, if you don't mind me jumping in at this point, is we're playing the same game that's played around here all the time, which is we say, "Well listen—we'd spend the money if we could just have at study, but we're then going to set the study up so that it demonstrates that we don't need to spend the money."

The reality is we're here to celebrate. There's a nice cake up here. We're here to celebrate the fact that there's a 25th anniversary of Medicare and Medicaid. The fact is that everybody knows that the elderly are no better off today than when that program was implemented.

Secondly, it does seem to me that what—since I've been in the Congress, every year what they do, the administration has come in and taken money out of Medicare and Medicaid to pay for the Federal deficit.

Now, we've got Federal deficit talks going on right now in Washington, DC. You've also got a lot of people here that probably would like to see national health insurance come about. But what happens is every single time that issue is raised to actually get on top of these questions, people say, "Oh, that's too bad, Joe. That's too bad, Mary Rose. That's too bad, Mr. Chairman. There's no money in the till." But the reality is that the way the system is currently being bled down, there is not going to be any money left unless we get on top of national health insurance.

Maybe Dr. Flemming or Mr. Lancaster might have a comment on where you feel we should be going and what you think—

Mr. LANCASTER. I agree with you 100 percent. I don't know how to do it. I'm not an expert that knows how to do it but, yes, they are broke. Why are they broke? They're paying $1,800 for toilet

seats and things of that kind. I'm not saying, "Cut the defense." What I am saying—

Mr. KENNEDY. We're saying, "Cut the defense." You can say it.

Mr. LANCASTER. All right. But what I mean, not just cut the defense. I mean, let the defense stop their bleeding us, you know, with these ridiculous kind of ways of living. The same has to be with doctors. The same has to be—the only reason I would uphold the acting problem, if you'll forgive me, is that it's an open marketplace. You see, it's a fair marketplace.

The reason that they pay some of these actors enormous sums of money, as they used to pay me in the old days too, is because we justified it at the box office. The things made a profit. If you took us out of the picture, it didn't do so well. So in a certain sense, by a little shenanigans, and by throwing my three balls in the air, I produced money for them. I was in the position to say, "Hey, give me some of that money. Don't you think I deserve a little more," that kind of thing.

But there's no reason that the Defense Department has to be so extravagant in the way it deals, or so negligible if that's the proper word in seeing what's happening with its own money or how it's being spent. They've got holes in their pocket, and when they walk along the street, everything falls out in the street, and then they don't even take a look back.

This is true of many wastes. Waste, waste, waste all over. Things of that kind, apart from even deviousness, I mean.

Mr. KENNEDY. You know, I—

Mr. LANCASTER. The answer is: you've got to find some way to get money financial help. Now—

Mr. KENNEDY. Mr. Lancaster, you know, you're not going to get some bolt of lightening, it is not going to come through this ceiling and zap you if you simply say that we ought to raise taxes on those individuals that can afford to pay because that's what this country should do.

Mr. LANCASTER. Well, then we'll—

Mr. KENNEDY. Some individuals' incomes have risen over 94 percent.

Mr. LANCASTER. Let them do it. We know damn well that we're going to have to raise taxes. They're in the process of being raised now, and everybody is picking booze because booze is the enemy of everybody, so we'll add another dollar to a bottle of booze, and nobody really gets upset about that. A bottle of beer is still—look at the bottles of wine. You pay $80 for a bottle of wine. To me, unless you're a real connoisseur and a real lover of wine, I suppose if you drink enough of it, you become a lover of it, but you don't pay $80 or $100 for a bottle of wine. I look at it and I think to myself, "No, come on fellows. Sorry."

Mr. KENNEDY. Dr. Flemming?

Dr. FLEMMING. Well, on this fundamental issue, as I tried to say in my opening statement, I think those of us who believe that the time has come for national health care should take note of the fact that there is a summit conference here and that it is altogether possible that some basic fundamental decisions will be made as a result of that summit conference that will have a major impact on people programs—

Mr. KENNEDY. That's right.

Dr. FLEMMING. —for the next 5 to 10 years. Now are we in there advocating for health care and insisting that included in those discussions would be additional funds for health care? I don't know whether that's going on or not. My feeling is that probably there is not too much of it going on, and somehow or other we've got to figure out how to get inside that system in such a way that that will become an item.

Now not just with the idea of adding on, but to take the $60 billion figure which is the price tag on the Pepper Commission recommendation. That is after it is fully implemented. I just take that by way of illustration. As Congresswoman Oakar indicated, that's about an increase of 10 percent over our existing bill. At the present time, we're paying about $600 billion.

Well, instead of regarding that as kind of an add-on, that should be put in as a part of the base. That should be regarded as an item that goes in there and is one of the untouchables because of its importance to the welfare of the people of this country.

As you know, I'm a strong advocate for improving our educational system. I believe that the Federal Government should be doing far more than it is doing at the present time, but here we are, we do recognize the right of access to our educational resources. Sometimes we do a pretty poor job of what we give them access to but, nevertheless, we recognize the right of access. Yet, there are millions of children and young people coming into that system with handicaps, physical and mental handicaps, that are going to be with them the rest of their lives, physical and mental handicaps that they would not have if they had—their pregnant mothers, or they themselves, had had access to health care.

It seems to me that's a must. That ought not to be trivialized in connection with these summit discussions. That should be regarded as a major item.

Mr. KENNEDY. Dr. Flemming, my time has expired, but the fact is, as Mary Rose Oakar just whispered to me, there is nobody with your perspective—and I think that the perspective of the people up here on this table at the moment—at that summit agreement. In fact, we're not going to see increases as a result of the summit. We're going to see decreases in Medicare and Medicaid spending, and it's going to be the working people and the poor that are going to be heard.

Mr. LANCASTER. Not enough importance is put upon it. In the scheme of things, not enough importance is put on it. The bills are paid by the people who can afford somehow or other. Their insurance doesn't really kill them so, therefore, we don't have to worry about the fellows. Let them get a job or something, you see.

But education is a little different, isn't it? We say in our minds, "Education, my God, we cannot drop that kind of cultural aspect. That's important." So even though I don't see much coming from it really—we've got a bunch of idiots anyway—the fact remains that we will have education, so nobody can accuse us of—we take that important. That's very important. That's as important as owning a baseball team. Therefore, we give it fair—we don't dismiss it.

But with—you get that in a hospital or anything. What are you worried about? I mean, we're doing the best we can. We would

never dare touch the Feds. If there were no wars and everything, we would go on building the Feds until it comes out of—we'd fight with ourselves or do something just to justify an Army, for crying out loud.

Mr. LANCASTER. You know, I mean, where are the brains that can look around and say, "Wait a minute." There is not going to be a war for a while. And say, "If we can cut this year for the half the budget or something, think what that will do to social programs." No, no, that's going to go on. You can tell it by the attitude. That's the number one thing. You've got to have it.

It's like hating the cops, but by God you're going to really have plenty of them around because we can't get along with them. They feel the same way about the Army.

The CHAIRMAN. The time of the gentleman has expired.

Mr. KENNEDY. Thank you, Mr. Chairman.

The CHAIRMAN. I think that the gentleman has focused on the real problem, the injustice of the system. I would like to pursue the questioning along those lines.

We have been told in the testimony that was read for Mary Bowden that Mary Bowden lives in a two-bedroom apartment. With her is Mrs. Brockman, the mother, a granddaughter, the great grandson, and I can just see that two-bedroom apartment being small and very inadequate.

But one thing that really struck me was the testimony with regard to income and then the comparison of the monies that Mr. Lancaster was referring to that we pay just for a toilet seat. Now let's just look at the differences.

Presently, we both receive Social Security and supplemental security income. This is Mrs. Brockman, or Ms. McKinley, saying this. My mother receives $256.80, that apparently is Social Security, and $22 Supplemental Security income. Now I went ahead and totaled these figures. That's $278.80 a month. Then, she says that she receives $266.80 and $28 from supplemental security income. Now that is $294.80. But you add them both together and they have a combined income from Social Security and supplemental security income of $573.60 per month.

With that, they also say "yes, but we also receive Medicare and medical assistance," which means had it not been for these programs that have been in place that we're celebrating this 25th anniversary today, they would not be receiving medical care at all.

Now take those $573.60 a month figures and then compare that with the cost of the toilet seat, which was in the neighborhood of $1,800—that's just for one toilet seat. I wonder how many were bought? 1,000? 2,000? 5,000? We don't know. Nevertheless, the cost is still there. We find a tremendous difference in what is being spent for medical assistance and for the care of the individual.

Now we've gone over and over this matter of medical care and its cost. We all must agree that the cost containment is not part of the present program. The cost of medicine is going higher and higher every day, and the question that was asked by Mr. Lancaster is: Why is it costing so much? He had other questions to ask with regard to cost, but the one thing—why is it costing so much? Why does it continue to increase more and more every day? What are we, as a Nation, doing to try to contain that?

Then, we find that when a committee does act, and I've had that experience in my own Committee on Health and Education, that we get a little reminder from the White House that, "If you do that, we're going to veto the bill." Let us find out, if we possibly can—and I'm sure that Dr. Wilensky is not the sole spokesman for the administration, and I realize that—but what, in your opinion, is the administration's goal with regard to long-term care?

Dr. WILENSKY. I don't think at the present time that the administration is prepared to go forward to say how it would like to see the program changed. It is one of the two major areas that we are looking at, both the uninsured and long-term care. That is part of the task force that I described. That is being done with a goal of trying to look at improving access to the care, keeping high quality, and making sure that there is cost containment included in it. It's one of the areas that I believe will be covered in whatever set of recommendations occur sometime around the end of the year.

The CHAIRMAN. Well, at the time the Pepper Commission released its first recommendations to Congress, we held a hearing, and we had a spokesman from the administration who told us that to implement the recommendations of the Pepper Commission would cost too much. We were also told that the Pepper Commission did not do a very good job because it was made up primarily of Members of the House and the Senate. I don't believe that, but that's what we were told.

They also said, "We now have under study a plan that is going to solve this problem, and it will be made available to you within 90 days." Those 90 days are long gone. Does the administration have a plan of some kind?

Dr. WILENSKY. I don't know who was speaking for the administration at that hearing. There has been concern raised by various people in the administration that the long-term care, and the other components of the Pepper Commission, did not have the specific mechanisms that they were recommending for the funding. Senator Rockefeller has indicated that, when the report is issued in the fall, it is anticipated that they will indicate how they propose to have the funding raised. To the extent that that happens, then I think those criticisms will be responded to.

Again, I'm not aware of anybody who would have said that the administration was going to have a proposal in 90 days. I think that both the Secretary—by the actions that he took last fall in putting together the task force that Mrs. Horner is chairing—and particularly the President—raising this as a specific issue in the State of the Union, and requesting that the Secretary, addressing him by name as the only cabinet member so addressed, look at these issues of cost, quality, and access—is indicating a very strong interest and commitment on the part of the administration in looking at these issues.

The CHAIRMAN. Dr. Wilensky, as a followup on that, I would like to know, how does the administration respond to the uninsured and underinsured whose hopes were dashed by Secretary Sullivan's apparent ruling out of comprehensive reform, which is probably the only way to get universal health and long-term care protection? How do you respond to the uninsured and underinsured?

Dr. WILENSKY. Well, I think perhaps if people had either heard or read the Secretary's statement, they might have felt differently. I have read what was reported in the newspaper, and I have also actually read the speech itself. I was not present in Atlanta when he gave it.

What the Secretary did say, and this to some extent was accurately reported, is that he did not believe that the administration, or that the Department, would advocate a nationalized system, per se. However, the Secretary also indicated that he believed that individuals ought to be able to receive necessary health care. We really ought to expand on our public and private system, that we ought to expand insurance availability.

Now precisely how, he did not indicate. I don't think the administration, at this particular time, is ready to. As I've indicated before, it won't be until—my best guess is—not before the end of the year. But the notion that the Secretary did not indicate either a sincere interest in this, or an attempt to look at and to try to have measured ways to remedy the situation is just not a correct reading of what he said.

The CHAIRMAN. Dr. Wilensky, do you know for a fact that that plan will be ready by the end of the year?

Dr. WILENSKY. No. I don't know for a fact that it will be ready by the end of the year because—

The CHAIRMAN. Is it rumored that it may be? What hope can we have?

Dr. WILENSKY. Well—

The CHAIRMAN. Because I would like to know, and I'm sure the members of the committee, and the Members of Congress, would like to know the exact position of the administration with regard to long-term care.

Dr. WILENSKY. I don't believe there has been, or at least I have not been personally aware of the specific timetable. The task force is actively working now within the Department, and there is a Domestic Policy Council work group that has been formed to both consider the recommendations of the Department as well as other recommendations such as the Pepper Commission and the Advisory Council on Social Security.

I believe that, had the President not had a sincere interest in looking at this issue, it wouldn't have been raised in the State of the Union with a specific request to the Secretary to look at these issues.

The CHAIRMAN. Dr. Wilensky, my time, of course, has more than expired. But Mr. Lancaster, in reference to the continuous cost of medicine, said, "Why is it costing so much?" Out of frustration, he is asking this question. This is what the public is asking. What we ask now is, "Why is it taking the administration so long to come up with their own plan?"

Dr. WILENSKY. Well, because I think that there are not easy answers to these problems. There are, and have been, as others referenced, a number of people who have looked at this and have laid out various options, but it is not easy to come to grips with the tradeoffs that you have to consider in terms of what we want to do—

The CHAIRMAN. Well, nothing worthwhile is easy.

Dr. WILENSKY. Well, that's correct. And that's why I think it ought not to be dismissed that the administration has been willing to indicate in a public way that it is addressing these issues of access, cost, and quality along with Members of Congress.

The CHAIRMAN. But you still can't tell us when?

Dr. WILENSKY. It's hard for me to tell because after the Department, it goes to the Domestic Policy Council for review. I don't know when they are going to report to the President, but I don't believe it will be before the end of the year.

The CHAIRMAN. Mr. Clarke?

Mr. CLARKE. Thank you, Mr. Chairman.

I know the purpose of the Medicare program. I've been a longtime supporter of it. I know that the job is to help people. I'd just like to say a word about it. In my district, it's primarily a rural district, two of my hospitals are in very acute financial condition because of what they say is that Medicare simply doesn't pay them as much as their services cost. I've got one small one that has closed its doors and another one that has 80 percent Medicare patients with a real—the loss of half a million dollars in the first 6 months, which is a lot of money for a small hospital.

And then I also held a meeting with the doctors in my district, along with representatives from HCFA and the Equicor, which is the paying agent for HCFA, and there seemed to be a lot of problems about billing and misunderstandings about what Medicare pays for and doesn't pay for. I realize again that that's the detail of the program but still it is a serious problem.

And then after the doctors had brought a lot of their problems to our attention, it was pointed out that last year doctors in North Carolina were paid more than $550 million by Medicare for their services, so it's an enormous thing we're really dealing with. I just wanted to bring those things up because that's been my experience in the last few weeks.

Thank you, Mr. Chairman.

Dr. WILENSKY. It reflects one of the problems. Everyone wants more, doesn't want to receive less, doesn't want to pay more. It's not that there aren't ways to make tradeoffs, but they're frequently not easy.

We are undergoing an attempt to see whether or not we can make what Medicare pays its hospitals and physicians more consistent and more uniform. We have heard from a number of places around the country of frustration by physicians and hospitals that they don't understand sometimes why other physicians seem to be paid different amounts doing the same kinds of services. Part of this will be taken care of in the new physician payment reform that was legislated last November, but we think it's also important to have our carriers, that is our contractors who do our billings for us, operate in a more uniform and consistent fashion. We are making very strong efforts to make sure that that happens.

We are also trying to look after the rural hospitals. There have been a number of special provisions that have been enacted, such as a sole community hospital program, and the rural transition grant, the EACH/PCH primary access and essential access programs, and the rural referral centers. We appreciate that a number of rural hospitals have been having difficulty. Frequently,

it is because many of their non-Medicare patients are leaving to go elsewhere. But to the extent that Medicare is contributing to their problems, we are interested to make sure that people are not left stranded and without medical services.

Mr. CLARKE. The critical issue with the rural hospitals is that their basic reimbursement is less than that of the urban hospitals. That's their critical argument.

Dr. WILENSKY. As you may know, we have a report due to Congress October 1 that is designed to look at the issue of single payment for urban and rural, along with adjusting for severity of illness and other measures. We anticipate that after Congress has looked at what we're recommending and the various options that, over the next several years, this will be remedied.

Mr. CLARKE. That would be good.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

I would like to come back and ask some questions of Mrs. Brockman, Ms. McKinley, and maybe one or two of Burt Lancaster and Dr. Flemming.

But before we do that, the Chair will now recognize Ms. Oakar.

Ms. OAKAR. Well, thank you, Mr. Chairman.

Mr. Chairman, our good friend Dr. Flemming, in his testimony, mentioned that we ought not to do this in a piecemeal approach. One of the reasons that I find my colleagues are talking about their individual problems and the response from Dr. Wilensky is so frustrating is that the fact is we are doing it in a very piecemeal, fragmented approach.

When you provide health care—and I want to repeat this, and I challenge anybody to challenge me on the figures. When you provide, when one provides a comprehensive program for every American and include long-term care, include prevention, include research, which we're way behind on, to find cures for Alzheimer's disease, and osteoporosis, and breast cancer, and all the other things that Americans spend billions of dollars for, and when you include a single payor, and the Government actually has a better track record of reimbursement than private insurance, which has a tremendous overhead. We learned this in the Pepper Commission. It's 22 percent overhead compared to 11 percent in terms of the Government-sponsored programs' overhead.

When you deal with this issue comprehensively, and you cover all people, and you have wellness programs, such as immunization for children, which reduces infant mortality and the cost of all that, and so on, you do it cheaper and you do it better. We can do better. It costs comprehensively $235 billion. It costs Americans right now $661 billion.

So when I see budgets that include—such as the Reagan/Bush budgets that had dramatic decreases for Medicare and Medicaid in their budgets, I have to challenge what commitment they have to improving the situation in this country. I think the chairman's question about when will we see your report, because we may have heard about that in the State of the Union address that the President was interested in this issue, but when you got the budget and you saw the cuts in Medicare, and we had to put them back, and then that—but you saw that the President wanted a $1 billion in

Starwars research and increased funds, you just have to say, "You know, what are our priorities in this country?"

So I welcome you to challenge me that it is not cheaper. We already pay for universal health coverage, but we're not doing it because just as we had in 1965, and Dr. Flemming, Wilbur Cohen told me about the challenges during those days—I served on a commission with him when he chaired a commission—he told me about the names they called all of you, communists and all these sort of red-letter items, tickets, we have the same kind of opposition to national health insurance today.

Yet I'm pleased to say that the American College of Physicians, the second largest physician group, is on record saying they are for it. So you can't say doctors aren't for it anymore because many of them are. The nurses are for it, and other health providers are for it.

The American people want it. Sixty-seven percent in polls say they want it. I just don't understand why we can't do it if it's cheaper and more comprehensive. I mean, what is stopping us? The chairman's asking a question about long-term care. He is a strong advocate for that. He and Senator Pepper had a fabulous bill that they put out that could have relieved the pain of so many people—8 million people in this country.

Do you challenge my statistics?

Dr. WILENSKY. I challenge at least some of them. I haven't seen how you calculated the $285 billion, so I'm not going to challenge that.

Ms. OAKAR. $235 billion.

Dr. WILENSKY. Excuse me.

Ms. OAKAR. Senator Rockefeller said in 5 years it will cost $235 billion.

Dr. WILENSKY. I have not seen how those are calculated. Let me challenge some of the figures that you did mention. For example, there are not cuts in the sense of absolute declines in either Medicare or Medicaid. What the President's budget had included was rather than a projected increase of 13 percent in Part B, a projected increase—if all of the reductions that were proposed, all of the changes that were proposed were included—in the neighborhood of 8 percent rather than 13 percent.

Similarly, in terms of the overall Medicare program, we proposed to take down the increase from 10 percent, a very large increase, to 5 percent, so the notion that we are talking about absolute cuts in these programs is not correct. It is a tried—

Ms. OAKAR. Let me just say to you that Medicare has been cut over 7 years $30 billion. Let me tell you what the effect is. The overall effect is an increase in out-of-pocket expenses for older Americans which rose 42 percent after adjusted inflation. You have to figure in inflation. During the last 7 years for elderly beneficiaries, costs climbed 1 to 5.2 percent times faster than their Social Security income. For women who were elderly, it was even more devastating since they're the poorest people in the country. Last year alone, Part B premiums of Medicare increased 38.5 percent. The elderly out-of-pocket expenses rose 12.7 percent, which was their out-of-pocket expenses before 1986 and rose 16 percent in 1986.

When you tell me, and with all due respect to Constance Horner, I have dealt with her many, many times. She used to be the head of OPM, the Office of Personnel Management, and I used to chair the committee related to employee benefits for Federal employees. What were their recommendations? Their recommendations were to cut medical care, to cut the pensions of Federal employees, to give them very often zero to minus 5 percent pay increases. I mean, I don't have a lot of faith in these task forces. I mean, I just have to tell you, we've got to get on with the show.

I want the President to be a hero, you know? I would support him all the way. It doesn't matter to me what party he is. He ought to come out for national insurance and quit lobbying people to be opposed to that. That's what he did with the Pepper Commission, and we were astounded that that would happen.

I was the only female member of that commission. I know a little bit about its proceedings. HCFA is just trying to turn the spirit of the law in poverty programs in my State and other States. You're issuing regulations that we never intended, that the indigent can't even get the insurance they're entitled to, so I'm telling you, we ought to say, "Thank God for Medicare and Medicaid." With all of its faults, and I don't quite agree with my colleague from Massachusetts, it has been an important program.

Dr. WILENSKY. I agree.

Ms. OAKAR. Without it, think of all the people who would have zero, all the more people who would have no insurance. So the fact is, that if you want to attack costs in this country and get to bottom line items with respect to deficits, be for universal health insurance. It will make us more competitive and it will help our people really compare, in terms of their needs, with, as Burt Lancaster said, Italy, and France, and England, and West Germany, and all the countries except for South Africa, including our northern neighbors. We could do better. I don't think anybody ever expected that we would be dormant for 25 years longer in terms of not doing anything for our people in terms of health care.

That's what I think this is all about, Mr. Chairman. Forgive me for going off on this but, after spending a year with respect to the Pepper Commission and studying this issue, the fact that we are seeing such tremendous resistance to it is just unbelievable to me. Our people will never be competitive in the world markets if they don't even have an anchor of health insurance. How are they going to survive and compete with West Germany when they're worried about whether they have health insurance covered?

Thank you, Mr. Chairman. I'm sorry to go off on it, but—

The CHAIRMAN. Thank you, Miss Oakar.

I would like to conclude the hearing in another 10 or 15 minutes. But I would like to ask Dr. Wilensky a question that I think we already agree on. That is with regard to a proposal that we've been working on that is designed to rebuild a somewhat strained relationship between Medicare and its beneficiaries.

I am pleased to know that you are working on a similar plan. Can you tell the committee very briefly what that plan is?

Dr. WILENSKY. We have a series of activities that we are engaging in to make the program more understandable. We are looking at all of the ways we provide information to the elderly in terms of

our booklets, the check stuffers that we use to send out information, the Medicare handbook, the explanation of Medicare benefits that go out.

We have convened a group within HCFA that is made up of people who come out of journalism backgrounds and communications backgrounds. We have sat down with groups representing the consumer groups. We had representatives of some 30 or 35 consumer groups in to meet with me a couple of days ago, both to request their help as we develop material in having them reach out to their own elderly populations to distribute them and also to give us guidance as to how to try to make this information more understandable.

We are planning to convene focus groups of the elderly. That is, bring groups into us or have us go out to them, and try to understand what it is about our programs that are not clear to them. We will be engaging in public service announcements and other media campaigns because we know a lot of the elderly have difficulty reading or our material is formidable.

We have also been working with the Social Security administrator, the Commissioner of Social Security, Gwen King, and with the Aging Commissioner, Joyce Sperry. We have recently signed a memorandum of understanding between HCFA and these other two agencies to set up an ability to work together closely.

We have recently, for example, tried to make use of the Social Security offices in a much more direct way with our recent release of the nursing home volume, so where we indicate on a nursing home-by-nursing home basis, deficiencies and problems that have been reported for each of the nursing homes—so we are seeking to work in a much more integrated way with the other parts of HHS, particularly the Administration on Aging and Social Security, and to also make sure that some of our populations that have particular difficulties in understanding our programs because they are non-English speaking, or because they may have some handicaps, are addressed in these efforts to make the program understandable.

We are very distressed by the amount of confusion that was evidenced during the catastrophic discussion and its repeal and also by what has become very clear in talking to people about basic confusion of the programs, so that we are making that one of our most serious undertakings and we will try to do as much as we can. We know this is an area of interest and look forward to working with the committee.

The CHAIRMAN. Thank you, Dr. Wilensky. You can be sure that this committee will do everything it possibly can to cooperate with you and your agency so that this program does, in fact, become a success.

Dr. WILENSKY. Thank you.

The CHAIRMAN. I would like to ask Mrs. Brockman. It just keeps on coming back to me, the testimony that was made on behalf of Mary Bowden.

First of all, I can't see how anyone can get along on less than $600 a month. But the one thing that has been left unresolved, as far as I'm concerned, is the state of affairs with regard to the grandson who has medical problems. We were told that he has

swollen glands, possible tonsillitis, but one thing that I think is even worse than all of that is the fact that the exact diagnosis is unknown because you cannot afford medical care. Moreover, Mrs. Bowden is overscaled for medical assistance.

Mrs. BROCKMAN. I am.

The CHAIRMAN. You are overscaled for—I want that clarification, Mrs. Brockman.

Mrs. BROCKMAN. My name is Mary Brockman.

The CHAIRMAN. All right.

Mrs. BROCKMAN. I am the granddaughter.

The CHAIRMAN. All right.

Mrs. BROCKMAN. When Mrs. Marshall came out to interview me, I asked her was I able to get a medical card for my son because by me working part-time at Safeway, they don't give you Medicaid for dependents, so I'm covered but that leaves my son not covered.

Okay. I am over the scale of $26, which leaves me not eligible for Medicaid just for him. So, therefore, I can't take him to the doctor unless I pay it out of my income. I was working 35 hours and was cut back for 30 hours, which I need the time to be home with my grandmother. Like I told Ms. McKinley and I told Mrs. Marshall, I refuse to put them in a nursing home. That's my future. I'm fighting for them. I have seen what nursing homes have done, and I have no reflect on nobody by putting their elderlies in a home but, for me, I fight.

I don't like the idea of a nursing home and for the figures of those Social Security—Medicare just cut their checks, Medicare, Plan B, which I was trying to explain to Ms. McKinley. I can't see where a Plan B program needs to be if they're getting Medicare from the State. Why cut their checks? I mean, before I took them, the condition there is—and to look at the way the system is. One State they provide need for the elderly, and Maryland don't. Maryland don't give the elderly anything.

The CHAIRMAN. Yes. All right.

Mrs. BROCKMAN. That's the reason I am here today because in DC they had home care, and they had a nurse to come out. Maryland—I just asked for 1 hour, and I get a whole lot of runaround for 1 hour in order just to have a home care visit.

And then I say, "Well, I could pay $15 a day to the State for home care." To me, it seems like they're arguing about something—a child, a young person having a baby. What about the old folks? I've got to get old, too. I want to know what my future is going to be when I get ready to apply for Social Security. How am I going to make it if every bill is cut?

I mean, I know this Congress got money, but I'm looking at the lower class. Like I was telling Miss McKinley, there are three kinds of homes that you can put peoples in—the higher class, the middle class, and the lower class. What about the lower class peoples? They be put into a home and they're forgotten about. Why? Because the family has to live. They have to work. They can't go to a home and see about—is they fed? Or are they—the pamper changed? I refuse to put mines in a home.

The CHAIRMAN. Well, Mrs. Brockman, I think the question that you ask, "How am I going to make it," is the one question that one can hear throughout this land, coming from thousands upon thou-

sands of individuals. This is one of the questions we hope we can, one of these days, answer.

Now, Mr. Lancaster, I understand that you're almost due for your flight, but maybe we can agree on something before you leave. Number one, your testimony today surely stirred this audience, and hopefully will stir many others who will hear your testimony in the future.

As a person whose career has been built on reaching out to the American public, I ask you this one question. You don't have to answer it now if you do not want to. Perhaps you can write this committee a letter. I am going to ask the same question of Dr. Flemming because we want something on record, some recommendations can be made.

I believe that the only way we're going to get a long-term care bill, or a national health plan, is if we have a groundswell of activity on the part of the people of this Nation. Now you are an expert in your profession. You have been able to inspire people, motivate them. You deal with the attitudes of people, as you perfect your profession. So the question is: How can we start developing that groundswell that will end eventually in a national health plan? I know it's a $64 million question. I've asked others that, and it's not something that can be answered on the spot. But will you write to me, or to the committee, and give us your opinion?

Mr. LANCASTER. I've just been informed by the gentleman behind me who is a New York representative of the Screen Actors Guild it is a question which they are working on now. I can add to that, although I won't try to answer your question, that it is the core of my philosophy about what life is really about—all life but, in our case, the human life, as to what our life is going to be. I don't know if I'm qualified to really, you know, give you any kind of an answer that is—but I'll just have to think about it, or can I promise you. That's all.

The CHAIRMAN. Fine. Also include the opinion of the Guild. Somewhere down the line I think this committee must have some direction. What can we do to develop that?

Dr. Flemming, will you do the same thing for us?

Dr. FLEMMING. First of all, Mr. Chairman, in responding to that question, I'd like to go back to a comment that you referred to about the composition of the Pepper Commission. I've been around here about 50 years and watching this process for 50 years. This is the first time, as far as I can recall, that the legislative process on a major issue has really been started by a joint committee of the House and the Senate. Now it isn't labeled that but, in effect, 12 out of the 15 members of this commission come from the House and the Senate. You have the help of three people that were appointed by the administration.

They subject this basic fundamental issue, all aspects of it, that we've been talking about, to the political process. I say that in a very positive way. It's got to be subjected to the political process. That's the only way we get results in this country.

They've come up with a series of recommendations which, as I indicated in my testimony, if—you just should take them as they are, enact them into law—yes. We would be writing into law a basic principle of universal right of access with a plan designed to

implement that. It would be a giant step forward in the area of long-term care. We'd have a start on cost containment.

But the Congress created this commission. This commission has now reported back to the Congress. The important thing is to make sure that this process now continues, that this report just doesn't gather dust, that it gets in to the committees that are in a position to report out legislation, and that they hold in-depth hearings.

Now I believe, as you've indicated, and others, that out of the grassroots, there is an overwhelming number of persons who believe as we do that the time has come for universal right of access to health care. They're anxious to take hold of a handle, to get hold of something specific. They're anxious to respond to a specific opportunity to give expression for their convictions.

Right now, as I work with a number of organizations, we're trying to say, "Get out to your people in the grassroots the message that they have an opportunity to get back to the Congress of the United States, to the Members of Congress and say, we want in-depth hearings, not just from Washington, but out in the country, on the Pepper Commission recommendations."

We're saying that doesn't mean you embrace every one of those recommendations. If you've got some other ideas, participate in the hearings. Put up your ideas, but give this process a chance to operate, and not operate year after next, but operate in this session of Congress. Why shouldn't these in-depth hearings get underway after the August recess? Why should we be waiting until a new Congress comes into session?

Now if we will ask out at the grassroots our people to undertake that specific responsibility, I think we'll get a response.

Mr. Chairman, I'd like to respond to one other issue that has recurred here. Time and again, a colleague, Mr. Lancaster, raised it. That's this issue of cost containment. We know that among our supporters these days are many leaders in the field of business and industry. They are supporting it primarily these days because they've made up their minds that you'll never have cost containment without a national health plan. They've tried it every other way. They've tried to change their plans, and the result is they've had strikes. That isn't very productive. So they're backing away from that and decided that the only way to have cost containment is through a national health plan.

Now I appreciate the fact that in the Pepper Commission an issue developed between the mandated approach, the single payer approach, and so on. Well, that's the kind of thing that should be thrashed out in the hearings and let the committees come up then with a solution. But if we have a national health plan, we will then be in a position where we can make some real progress on cost containment.

On the funding side of it, it isn't idle to think about getting money set aside for this. The people do believe in this. If certain revenues were earmarked for this, we could get a crusade going out of the grassroots on behalf of that increase in revenues earmarked for this particular purpose that would be overwhelming.

Let's give the people a chance to vote on whether or not they are willing to pay for a national health plan that gives us a real start

on long-term care. If we give them that chance, they'll respond and they'll respond in an overwhelming manner, in my judgment.

The CHAIRMAN. I'd like to thank you, Dr. Flemming, Mr. Lancaster, Dr. Wilensky, Ms. McKinley, and Mrs. Brockman, for your testimony.

This has been a most interesting hearing, but we still have a long way to go. I hope that, down the line, we can join hands and accomplish everything we talked about today.

Thank you very much.

[Whereupon, at 3:38 p.m., the hearing was adjourned.]

APPENDIX I

MEDICARE AND MEDICAID'S 25TH ANNIVERSARY — MUCH PROMISED, ACCOMPLISHED, AND LEFT UNFINISHED

A REPORT

By The

CHAIRMAN

Of The

SELECT COMMITTEE ON AGING

HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

Second Session

July 1990

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PREFACE

In 1985, we labeled the 20th anniversary as a "bittersweet" occasion because the history of Medicare and Medicaid is replete with many accomplishments, many problems and many gaps. On the occasion of the 25th anniversary of these two key health protection programs, the label still applies and the feeling is the same. While there has been some progress, much of the promise and hope enshrining these two programs remains unfulfilled.

As is shown in this report, there is much of which to be proud with respect to Medicare and Medicaid. Each year since Medicare and Medicaid began, millions of Americans who are poor, are elderly or have major disabilities have received care funded by these two programs. Medicare has relieved a large portion of the financial burden of acute care costs for its beneficiaries. Medicaid has taken away the financial burden of acute and long term nursing home costs for those who became Medicaid beneficiaries. This is no small accomplishment during a time when health care costs have skyrocketed and America has seen its elderly population grow significantly and its poor population remain substantial. Much to their credit, Americans of all ages have continued to support these programs not only with their words but with their tax and premium dollars.

But there is another side to this success story. For all their accomplishments, the Medicare and Medicaid programs have problems. Rising health care costs have put enormous pressure on these programs, the American taxpayer, and the beneficiaries. Even with more than a decade dedicated to cost containment, effective cost containment is still out of our reach. As just one example, our own study has shown that today's elderly are spending nearly one-fifth of their income on health care, one and one-half times higher than the level in 1977.

Over the past 25 years, quality assurance efforts have made major strides forward but have still to fully address health and long term care quality in many settings, including ambulatory care and home care. Further, much of today's quality assurance is tied to Medicare and, to a lesser extent, Medicaid leaving the privately insured and the uninsured without adequate protection. Also, quality assurance has acquired a new rationale in a period of cost containment. Much more than in the past, quality assurance can become a means for measuring the impact of cost containment policies and documenting when and where cost containment may do or be doing damage.

For all the people who have been protected by these programs, there are many more who remain unprotected. Today, 31-37 million Americans are uninsured for health care at any point in time. Nearly twice that number experience being uninsured in a two year period. Many millions more remain at risk as their insurance is woefully inadequate to meet the challenges and the costs of modern day health care.

Since 1965, long term care protection has emerged as a weak spot in our system. Today, over 200 million Americans are uninsured against long term care costs and the only large scale program protecting younger and older Americans is Medicaid. Unfortunately, a person's price of admission to Medicaid and its long term care protection is either being poor or spending down into poverty.

Turning to the future, it is again likely to be a time of great turmoil for health and long term care in America. Unless we enact large scale reform, health and long term care costs are likely to continue to outstrip our ability to pay for them. Without large scale reform, the number of Americans without health insurance will remain over 30 million and the number of Americans without long term care insurance protection will remain over 200 million. None of these "status quo" situations is tolerable.

Today, we are fortunate to have many reform proposals on the table from a wide spectrum of organizations, coalitions and members of Congress. Many of the proposals would shore up one or more of the weak spots and gaps in Medicare, Medicaid or private insurance protection. Some proposals focus more on private sector solutions while other focus more on public sector strategies.

More and more proposals are being designed to bring about comprehensive health and long term care reform. Some, such as my own USHealth Act (H.R. 2980), lean toward a federally-based, nationwide program built upon Medicare and covering health and long term care. Some comprehensive proposals, like the Pepper Commission recommendations, use employer-mandated health insurance, Medicare and an improved Medicaid-type program to ensure health and long term care protection. In addition, more and more interest is also being shown in using part or all of Canada's system as a basis for comprehensive reform. What is promising is that comprehensive reform continues to pick up supporters from a broad spectrum of the American public and that there is a substantial openness to different approaches, as long as they accomplish the goal of ensuring protection for all Americans.

Over the past 25 years, much has been promised and much has been accomplished with respect to Medicare and Medicaid. However, the final chapter on health and long term care reform in America is far from having been written as much is left unfinished. The task now falls to the Administration and Congress, the public custodians of Medicare and Medicaid, to complete the agenda and to ensure that no American lacks financial access to needed health and long term care care and that no American need fear financial and emotional ruin from costly and disabling illnesses.

EDWARD R. ROYBAL
Chairman, House Select Committee on Aging

ACKNOWLEDGEMENT

The Chairman would like to express his deep appreciation to Dr. Tony Hausner, a Health Care Financing Administration employee on detail to the Select Committee on Aging, for his valuable assistance in helping draft this report commemorating the 25th anniversary of the Medicare and Medicaid programs.

EXECUTIVE SUMMARY

Twenty-five years ago on July 30, 1965, President Johnson signed into law the Medicare and Medicaid programs as Titles XVIII and XIX respectively of the Social Security Act. As enacted, the Medicare program was designed as a national, federally administered program with uniform eligibility and benefits tied to the Social Security program. Part A, the hospital insurance program, provides protection for mostly inpatient acute care; while part B, the supplementary medical insurance fund, covers doctor visits and other ambulatory services.

The Medicaid program is a Federal grant program which is administered by the States and is targeted toward lower income individuals and families. It covers a broad range of hospital, nursing facility and other medical services.

When these programs were enacted, many persons expected that Medicare and Medicaid would ensure full coverage of all health care services for the elderly, disabled, and the poor. While these programs have gone through many changes in their 25 year history, and much has been accomplished during this time period, this report will indicate that there remain many gaps and weaknesses in the programs.

Accomplishments. The Medicare and Medicaid programs have made many important contributions to the health care needs of the elderly, disabled, and the poor. The following statistics give some indication of this contribution. In 1989, society contributed over $120 billion to parts A and B of the Medicare program, and $54 billion to the Medicaid program. These programs have primarily been funded by the taxpayer though Social Security and general income taxes, and by the elderly through these taxes and through premiums.

Over the years, these programs have served many beneficiaries, and, therefore, have provided them access to health care and protected them from much of the burden of considerable health care costs. In 1989, Medicare served 32.5 million beneficiaries and Medicaid served 23.5 million beneficiaries. An examination of a few key services gives an even better perspective on these programs' contributions. In 1987, Medicare provided nursing home care to 300,000 persons, and physician and other medical services to 23 million persons. For Medicaid in 1988, the number of beneficiaries who received skilled and intermediate nursing home care was 1.59 million and the number who received physician services was 15.26 million.

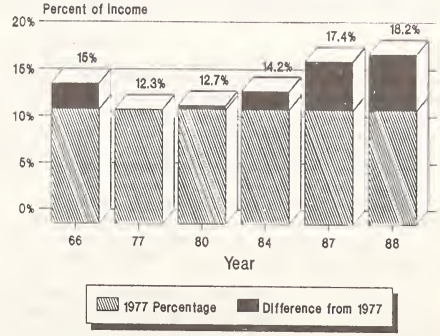
Gaps and Weaknesses in Medicare and Medicaid. Despite the many accomplishments of these programs, there still remain many gaps and weaknesses that need to be resolved.

Health care costs have been rising more rapidly than the cost of living for at least the past two decades. This has created problems for the entire health care field, for Medicare and Medicaid, and for the elderly, the disabled, and the poor. For instance, between 1983 and 1989 medical care prices rose at twice the rate of inflation. For the elderly and others with lower, relatively fixed incomes, this has particular consequences. The elderly's out-of-pocket costs increased from 12.3 per cent of their income in 1977 to 18.2 per cent in 1988 (see Figure E.1).

Over the past 25 years, quality assurance efforts have made major strides forward, but have still to fully address health and long term care quality in many settings, including ambulatory and home care. Further, much of it is tied primarily to Medicare, and, to a lesser extent, Medicaid; whereas the privately insured and uninsured have little protection.

FIGURE E.1 — .

Elderly Out-of-Pocket Health Costs
As A Percent Of Elderly Mean Income



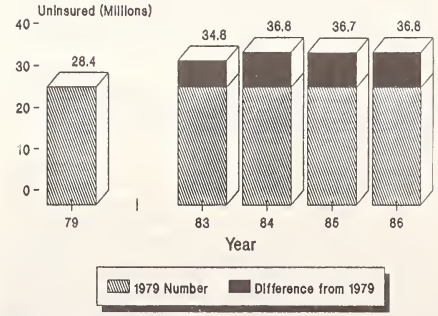
Source: House Committee on Aging, 1990

Medicare and Medicaid also have many gaps as to services and persons covered. The Catastrophic Care Act of 1988, repealed in 1989, identifies one set of services that are not covered. There are long term care services, dental services, and other services that are not covered by these programs. Another gap is that Medicaid only covers 42 per cent of persons below the poverty line. Medicaid also suffers from low participation by many hospitals, physicians, and other providers.

A further gap of great importance is the number of persons who are un- and underinsured. Studies show that the number of persons who have no health insurance has grown from 28 to 37 million persons between 1979 and 1986 (see Figure E.2). When facing a catastrophic acute or long term illness, over 200 million Americans are underinsured.

FIGURE E.2 — .

Nonelderly Without Health Insurance
1979 and 1983 to 1986



Source: Current Population Survey,
Census Bureau

Future of Federal Role in Health and Long Term Care. Fortunately, there are many reform proposals on the table from a wide spectrum of organizations, coalitions, and members of Congress. One set of proposals represent expansions and improvements to the Medicare and Medicaid programs.

A second set of proposals are designed to bring about comprehensive health and long term care reform. Some, such as Congressman Roybal's USHealth Act (H.R. 2980), lean toward a federally-based, nationwide program built upon Medicare and covering health and long term care. Some comprehensive proposals, like the Pepper Commission recommendations, use employer-mandated health insurance, Medicare and an improved Medicaid-type program to ensure health and long term care protection. In addition, more and more interest is also being shown in using part or all of Canada's system as a basis for comprehensive reform. What is promising is that comprehensive reform continues to pick up supporters from a broad spectrum of the American public and that there is a substantial openness to different approaches, as long as they accomplish the goal of ensuring protection for all Americans.

Looking to the future, the nation has two responsibilities. The first responsibility is one of stewardship over Medicare and Medicaid as they are today. The second responsibility is to those who have yet to benefit from this nation's greatest step forward toward protecting the health of its citizens.

When millions live at risk and in fear of a long term disabling illness wiping out the financial and emotional resources of their families, a nation cannot be satisfied with Medicaid as the nation's primary long term care policy. When millions are forced to seek charity for whatever health care they need, a nation can feel no pride in having the best medical care in the world.

In a world which has increasing doubts over the United States' ability to step forward and show leadership on the great issues of the day, health and long term care protection is one case where this nation not only fails to lead but fails to keep up. Twenty-five years would seem to have been enough time for this nation to take its rightful place of leadership; thirty years would seem to be too long.

NOTE: For further information on the Committee's consideration of the Medicare and Medicaid programs and their future, contact Gary Christopherson, Yvonne Santa Anna, Dr. Tony Hausner or Carolyn Griffith at the House Select Committee on Aging, Room 712, House Annex 1, Washington, D.C. 20515. Phone: 202-226-3375.

INTRODUCTION

On the 25th anniversary of Medicare and Medicaid, the two largest government efforts to ensure protection for its citizens health, it is important to reflect upon the history of these critical programs and to dedicate the nation to future efforts to fulfill their great promise.

In the course of this report by Chairman Roybal of the Select Committee on Aging, an effort will be made to examine how the programs came about and what was hoped they would accomplish. Based upon implied promises and the actual legislation enacted, this report reviews Medicare and Medicaid as they were when enacted into law on July 30, 1965 and the considerable changes that have occurred since their enactment. Over the past 25 years, laws have been enacted to expand eligibility and coverage of services, to improve methods of paying for services, to strengthen efforts to assure the quality of services provided, and to constrain the rate of growth in program expenditures. Over the last 15 years, cost containment has emerged as a major priority and, in some peoples' view, the major priority. Other people believe that the major priority is the effort to expand eligibility to cover the uninsured and to expand coverage for long term care.

However, to look only at the legislation would be to lose sight of the great value of what society contributes and what the elderly, poor and disabled receive. In that regard, the report will measure society's contribution not only by their 25 years of unwavering political support but also their financial contributions through income taxes, payroll taxes, and premiums. The value of Medicare and Medicaid can be measured in many ways. One way is the the benefits received, e.g., the people receiving care in hospitals, nursing homes and from physicians. Another, less tangible, way is the increased financial and emotional security of Medicare and Medicaid beneficiaries.

Within the story of people protected and benefits received, is the other story. This is the story of people left unprotected and of health and long term care left uncovered. In one case, it is the nation's inability to constrain health and long term care costs to keep them affordable for everyone, whether they be government, employer or individual. Another case is the 30 plus million people without health insurance. Another is the 200 plus million people without long term care protection, except for the prospect of Medicaid. No matter how people view the limitations of Medicare and Medicaid, virtually everyone agrees that the elderly, poor and disabled are far better off with them. Most agree that much work lies ahead for the nation.

Finally, a proper consideration of the 25th anniversary of Medicare and Medicaid must include a view to the future. As will be shown in this report, much work remains before the Medicare and Medicaid's gaps and weaknesses are repaired and before their full promise is achieved. Whether their full promise is best achieved through the repair and refinement of Medicare and Medicaid or through a comprehensive reform building upon the experience of Medicare and Medicaid is what will dominate the health policy debate of the next decade.

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THE PROMISE.

History Of Efforts Prior To Medicare and Medicaid. The foundations of Medicare and Medicaid are first found in the passage of the Social Security Act of 1935 and then in a series of medical programs in the 1950's which consisted of medical payments for certain needy individuals, all of which were linked to cash welfare programs, as is today's Medicaid program. In 1950, Congress authorized a strategy of vendor payments for medical assistance to the aged, blind, and disabled. Then in 1956, they added disability insurance benefits. In 1960, the Kerr-Mill amendments were approved which covered the needy aged. Extensive criticism was directed at this legislation because it did not cover the majority of the aged.

At that time, private health insurance covered some but not all of the elderly. A 1963 survey showed that only 56 percent of the elderly had hospital insurance (see Health Care Financing Administration (HCFA), 1985). Yet the aged were identified as being at considerable risk since they had the highest rates of illness and, at that time, the lowest incomes. It was with this as background that Medicare and Medicaid were enacted.

Enactment Of Medicare and Medicaid. Medicare was enacted into law on July 30, 1965 as Title XVIII of the Social Security Act. It was designed as a national, federally administered program with uniform eligibility and benefits and was tied to the Social Security program. The hospital insurance program, part A, provides protection for acute care needs with benefits structured around episodes of illness. It covers all expenses for the first 60 days minus a deductible; for days 61-90, a coinsurance amount is deducted. When more than 90 days are required in a benefit period, a patient may elect to draw upon a 60 day lifetime reserve. A coinsurance amount is deducted for each reserve day.

Part A will also pay for up to 100 days in a skilled nursing facility; after the first 20 days, a daily coinsurance amount is deducted. Subject to need, it also pays for home health visits for homebound individuals.

Medicare Part B, the supplementary medical insurance fund, pays 80 percent of approved charges and covered services in excess of an annual deductible. Covered services include doctor visits, such as surgery, consultation, home, office, and institutional visits; other medical and health services, such as laboratory and diagnostic tests, radiation, therapy, outpatient services, artificial devices, physical and speech therapy, and ambulance services; and home health services not covered by part A.

Medicaid was also enacted on July 30, 1965 as Title XIX of the Social Security Act. It is a Federal grant program which is administered and partly funded by the States and is limited to low income individuals and families. It covers those persons eligible for existing welfare programs. In addition, States may provide for the medically needy who are individuals not eligible for cash assistance because of income limits but whose medical bills exceed their income to the point that they meet the states medically needy standards.

Title XIX requires that every State offer hospital inpatient and outpatient care, laboratory and X-ray services, skilled nursing facility services, physician services, family planning, and early and periodic screening, diagnosis, and treatment for persons under 21 years of age. In addition, States may provide a number of other services at their option, including prescription drugs, eyeglasses, intermediate care facility services, inpatient psychiatric care, physical therapy, and dental care.

Modification Of Medicare And Medicaid Since 1965. There have been extensive changes to the Medicare and Medicaid programs since their enactment. This section will highlight some of the key changes first to Medicare and then to Medicaid.

The 1972 Social Security Amendments added the following provisions to the Medicare program: coverage to disabled persons receiving cash benefits for 24 months under the social security program and persons suffering from end-stage renal disease; and Professional Standards Review Organizations in which medical and health care professionals reviewed the medical care delivered by Medicare providers.

The 1982 Amendments added the following provisions: hospice coverage for the terminally ill; encouragement of the Medicare program to contract with Health Maintenance Organizations and other Competitive Medical Plans; and the replacement of Professional Standards Review Organizations by Peer Review Organizations. The latter program involved the replacement of a grant program by a contract program with more specific objectives. The 1983 Amendments established the Hospital Prospective Payment System in which hospitals are paid a set rate for each Diagnosis Related Group. This payment system replaced the previous method of reimbursing hospitals for all reasonable costs and is designed to promote greater efficiency in the delivery of hospital services.

In 1988, the Medicare Catastrophic Care Act was enacted but most of its provisions were subsequently repealed in 1989. The Act was designed to remove payments for coinsurance and limitations on the number of days of hospital care; limit to only one inpatient deductible per year; expand skilled nursing facility, home health, and hospice care benefits; and place limits on out of pocket expenses for part B services; and cover outpatient prescription drugs. The bill also contained several Medicaid provisions to be discussed below. The Medicare provisions were to be financed by an increase in the Part B premium and a new supplemental income-related premium (also referred to as a surtax) on all part A enrollees with tax liability (estimated to affect about 41 percent of the elderly in 1989). Many elderly complained about the supplemental premium and the limited advantages of the new benefits. The Medicare Catastrophic Care Act was repealed in 1989, except for the Medicaid provisions noted below.

In 1989, the President signed a budget reconciliation bill that included reforms in physician payment. The new payment system uses a relative value scale that takes into account the time, intensity, and skill of the services rendered rather than physician historical charges. It also includes a geographic adjustment factor and a volume performance standard.

In addition to these changes, the Administration and Congress have modified the Medicare program through a variety of other budget controls. These controls have taken the form of reductions or freezes in provider payments and increases in beneficiary premiums and deductibles. Between 1981 and 1987, the General Accounting Office (GAO) and HCFA estimated that these budget changes resulted in cuts of about $40 billion. Some believe that the cuts may have been even larger.

Medicaid has also gone through many changes over the years. In 1981, legislation permitted the States to exercise two options: the freedom of choice option allows the States to restrict individuals to certain providers; and home and community based waiver option allows the States to substitute such services for institutional services. Starting in 1984, legislation has been modified several times to gradually expand the population groups that States are either required or permitted to cover. The connection to cash assistance is still the primary, but no longer the only way to establish eligibility. When the latest provisions are fully implemented, States will be required to cover all pregnant women and infants below the poverty line and all children under 7 years of age meeting State eligibility standards. States also have the option to cover pregnant women and infants up to 185 percent of the poverty line. Further, as discussed below, States will be required to pay Medicare cost-sharing charges for the elderly and disabled Medicare beneficiaries with incomes below the poverty line.

Further changes in Medicaid included the 1987 Nursing Home Reform provisions that established a more uniform and stringent set of quality assurance standards for nursing homes. Finally, the Medicaid provisions retained in the Medicare Catastrophic Care Act include: coverage of Medicare premiums, deductibles, and coinsurance for individuals below the poverty line; and protection of portions of the income and assets for the spouse of an institutionalized individual.

While their have been a number of program expansions to Medicaid, there have also been a series of budget cuts to this program. In particular, budget bills in 1981 and 1982 reduced the program by over $4 billion from what many people believed was already an inadequate program of protection. While there have been modest improvements in the program since then, as of 1987, the Congressional Budget Office (CBO) estimated that the expansions restored less than 10 percent of these earlier cuts.

The Promise. Many people expected that the enactment of Medicare and Medicaid would ultimately protect the elderly and poor persons from burdensome health care costs. When President Johnson signed these bills, he stated:

> "No longer will older Americans be denied the healing miracles of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years."

Medicaid also had far-reaching goals. The poor were promised that they would soon have access to mainstream medical care and that health care was a basic right.

However, the original intent of these programs was primarily to address the acute care needs of the elderly and the poor. Chronic long term care was not included. One reason that long term care was not included was that it was not as great a factor as it is today. To avoid opposition by the advocates of States rights, Congress further compromised by conceding much of the control and administration of Medicaid to the States. These compromises, as well as many other gaps and weaknesses, mean that this nation is still a long way from meeting the original dreams of Medicare and Medicaid.

ACCOMPLISHMENTS.

The Medicare and Medicaid programs have made many important contributions to the health care needs of the elderly and the poor. The following information give some dimensions to this contribution. Unfortunately, there is little information that indicates the direct effects that the provision of these services has had on the health status of the effected populations. It can only be assumed that these populations have received care that they would not have received otherwise; and, therefore, this has led to improvements in their health status.

Society's Contribution. Over the past 25 years, society has made an unwavering and significant contribution to protecting the health of the elderly, disabled and poor. As one illustration of that contribution, Table 1 indicates the total income from various components of society for the Medicare hospital insurance fund. The sources of income include payroll taxes, transfers from railroad retirement accounts, reimbursement for uninsured persons, premiums from voluntary enrollees, payments for military wage credits, and interest on investments and other income. In 1989, the fund received $76 billion. Most of the funds come from the social security payroll tax which applies to all persons who work whether or not they are over or under age 65. Thus, all components of society contribute to this fund.

A similar picture is shown in Table 2 which provides data for Medicare Part B and its supplementary medical insurance trust fund. Income is derived from beneficiary premiums, government contributions, interest, and other income. In 1989, the fund received $44 billion. Most of these funds come from government contributions, primarily income taxes. However, a significant portion, about one-quarter, does come from the premiums paid by beneficiaries.

TABLE 1 — INCOME SOURCES FOR THE HOSPITAL INSURANCE TRUST FUND, CALENDAR YEARS 1966-92.

Income (In Millions)

Calendar Year	Payroll Taxes	Interest & Other Income	Misc. Income *	Total Income
1966	$ 1,858	$ 32	$ 53	$ 1,943
1967	3,152	51	356	3,559
1968	4,116	74	1,097	5,287
1969	4,473	113	693	5,279
1970	4,481	158	1,340	5,979
1971	4,921	193	618	5,732
1972	5,731	180	492	6,403
1973	9,944	278	599	10,821
1974	10,844	523	657	12,024
1975	11,502	664	814	12,980
1976	12,727	746	293	13,766
1977	14,114	784	958	15,856
1978	17,324	834	1,055	19,213
1979	20,768	975	1,082	22,825
1980	23,848	1,149	1,100	26,097
1981	32,959	1,603	1,163	35,725
1982	34,586	2,022	1,390	37,998
1983	37,259	2,593	4,718	44,570
1984	42,288	3,046	1,386	46,720
1985	47,576	3,362	459	51,397
1986	54,583	3,619	1,065	59,267
1987	58,648	4,469	947	64,064
1988	62,449	5,830	960	69,239
1989	68,369	7,317	1,035	76,721
Alternative II-B Projection				
1990	71,429	8,520	577	80,526
1991	76,252	9,812	1,123	87,187
1992	81,041	11,034	893	92,968

* Miscellaneous income includes transfers from railroad retirement, reimbursement for uninsured persons, premiums from enrollees, and military wage credits.

SOURCE: Health Care Financing Administration, 1990.

TABLE 2 — INCOME SOURCES FOR THE SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND DURING CALENDAR YEARS 1966-92.

Income (In Millions)

Calendar Year	Premiums From Enrollees	Government Contributions	Interest & Other Income	Total Income
1966	$ 322	$ 0	$ 2	$ 324
1967	640	933	24	1,597
1968	832	858	21	1,711
1969	914	907	18	1,839
1970	1,096	1,093	12	2,201
1971	1,302	1,313	24	2,639
1972	1,382	1,389	37	2,808
1973	1,550	1,705	57	3,312
1974	1,804	2,225	95	4,124
1975	1,918	2,648	107	4,673
1976	2,060	3,810	107	5,977
1977	2,247	5,386	172	7,805
1978	2,470	6,287	299	9,056
1979	2,719	6,645	404	9,768
1980	3,011	7,455	408	10,874
1981	3,722	11,291	361	15,374
1982	3,697	12,284	599	16,580
1983	4,236	14,861	727	19,824
1984	5,167	17,054	959	23,180
1985	5,613	18,250	1,243	25,106
1986	5,722	17,802	1,141	24,665
1987	7,409	23,560	875	31,844
1988	8,761	26,203	861	35,825
1989	12,263	30,852	1,219	44,334
Alternative B Projection				
1990	11,125	32,455	1,285	44,865
1991	11,781	36,492	1,216	49,489
1992	12,445	42,705	1,076	56,226

SOURCE: Health Care Financing Administration, 1990.

Another measure of societal contribution is the amount of expenditures for Medicare beneficiaries. Table 3 indicates the growth in Medicare expenditures between 1967 and 1989 with projections through 1995. In constant 1990 dollars, expenditures will have increased from $1,104 per enrollee in 1969 to $4,228 in 1995, a four-fold increase. For that period, the growth rate was fairly steady between 1975 and 1985 at around 7 percent and then decreased to 3.1 percent for 1985-1991 due to a decrease in hospital expenditures. Based on current law, the rate is projected at 6.2 percent for the 1991-1995 period.

Significant growth has also occurred for the Medicaid program. Table 4 shows that real spending per beneficiary has increased 133 per cent between 1975 and 1989, an annual growth rate of 1.9 per cent. More recently, the spending growth rate has slowed down. Between 1975 and 1980, it increased at an annual rate of 4.2 per cent. Between 1980 and 1989, it increased at a much slower annual rate of 0.9 per cent. In 1989, Medicaid spent $54 billion in combined Federal and State funds.

These data indicate that the Medicare and Medicaid programs have expended an extensive sum of funds to pay for the health care for the elderly, disabled, and the poor over the past 25 years. They also indicate that, for the most part, these programs have been strongly supported and paid for by the taxpayer, through Social Security taxes and general income taxes. The elderly have helped to pay for their coverage through these same taxes during their working and retirement years and by premiums during their retirement years.

Beneficiaries Protected. Over these last 25 years, many millions of beneficiaries have been served by these two programs, and, therefore, have been provided access to health care and protected from a substantial portion of burden of considerable health care costs. Figure 1 and Table 5 shows that the number of aged and disabled Medicare enrollees will continue to grow, rising from 23 million in 1975 to an estimated 36 million for 1995.

TABLE 3 — REAL MEDICARE SPENDING PER ENROLLEE, 1967-95.

(In Constant 1990 Dollars)

Fiscal Year	Medicare Spending
1967	$ 648
1968	960
1969	1,104
1970	1,114
1971	1,143
1972	1,194
1973	1,100
1974	1,182
1975	1,355
1976	1,481
1977	1,637
1978	1,744
1979	1,811
1980	1,954
1981	2,117
1982	2,300
1983	2,449
1984	2,554
1985	2,775
1986	2,817
1987	2,886
1988	2,960
1989	3,079
Congressional Budget Office Projection	
1990	3,230
1991	3,328
1992	3,576
1993	3,794
1994	4,012
1995	4,228

SOURCE: Health Care Financing Administration and Congressional Budget Office, 1990.

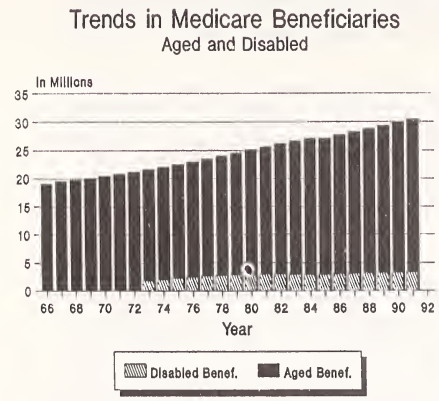
TABLE 4 — REAL MEDICAID SPENDING PER BENEFICIARY 1975-89.

(In Constant 1982-84 Dollars)

Fiscal Year	Medicaid Spending
1975	1,171
1976	1,188
1977	1,248
1978	1,325
1979	1,409
1980	1,441
1981	1,493
1982	1,471
1983	1,494
1984	1,469
1985	1,515
1986	1,493
1987	1,498
1988	1,534
1989	1,553

SOURCE: Health Care Financing Administration, 1990.

FIGURE 1 — MEDICARE BENEFICIARIES, 1966-1995



Source: Health Care Financing Adm., 1990

TABLE 5. — MEDICARE AND MEDICAID BENEFICIARIES.

Beneficiaries (In Thousands)

Fiscal Year	Medicare Aged Benef.	Medicare Disabled Benef.	Medicaid Benef.
1966	19,082		11,500
1967	19,494		12,060
1968	19,770		14,507
1969	20,014		17,965
1970	20,361		17,741
1971	20,742		18,466
1972	21,115		21,114
1973	21,571	1,731	19,622
1974	21,996	1,928	21,462
1975	22,472	2,168	22,006
1976	22,920	2,392	22,815
1977	23,475	2,619	22,832
1978	23,984	2,793	21,965
1979	24,548	2,911	21,520
1980	25,104	2,963	21,605
1981	25,591	2,999	21,980
1982	26,115	2,954	21,603
1983	26,670	2,918	21,554
1984	27,112	2,884	21,607
1985	27,123	2,944	21,814
1986	27,728	2,986	22,515
1987	28,239	3,042	23,109
1988	28,779	3,115	22,907
1989	29,358	3,200	23,511
1990*	29,951	3,251	24,600
1991*	30,480	3,297	25,600
1995*	32,277	3,597	

* Estimate

SOURCE: Health Care Financing Administration, 1990.

As seen in Figure 2 and Table 5, there were substantial increases in the number of Medicaid beneficiaries between 1968 and 1974, the early years of the program. Since then the numbers have remained fairly steady between 21.5 and 23.5 million. The Census Bureau's Current Population Survey indicates that between 1980 and 1988 the number of Medicaid beneficiaries who were below the poverty line was also fairly constant at 12 to 13 million.

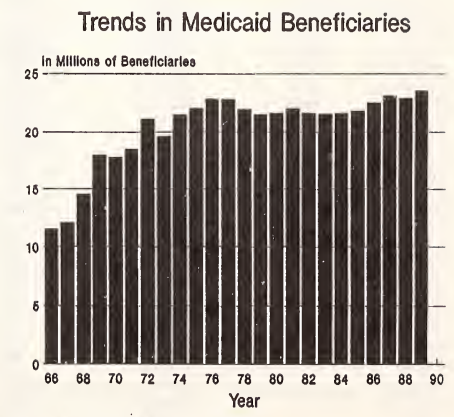
Care Provided. An examination of persons served and expenditures for different types of services provides a further perspective on the contributions that Medicare and Medicaid have made in providing health care to the elderly, disabled, and the poor. This examination will focus on physician and nursing home services, since they are good barometers of the influences of these programs.

With respect to nursing home services, Table 6 shows that the number of elderly who have received nursing home services under Medicare has stayed relatively constant at around 300,000 between 1967 and 1987. For physician and other medical services, the pattern is much different since the number served has increased from 6 to 21 million persons during this time period.

Looking instead at the proportion of Medicare dollars (expected to be $113 billion in 1991) going for different services, approximately 54 percent will be spent on hospital inpatient services and 29 percent on physician services. These figures contrast sharply with the 1975 proportions of 70 percent and 22 percent for these services respectively (see Figure 3). Thus, there has been some shift from hospital to ambulatory care over the past 15 years.

Moving to Medicaid, Table 7 shows that the number of Medicaid beneficiaries using nursing homes (skilled and intermediate) has increased from 1.14 to 1.59 million between 1973 and 1988. During the same period, the number using physician services has increased from 12.28 to 15.26 million.

FIGURE 2 — MEDICAID BENEFICIARIES, 1966-89



Source: Health Care Financing Adm., 1990

TABLE 6. — MEDICARE BENEFICIARIES SERVED BY TYPE OF SERVICE.

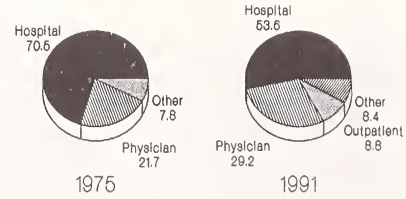
(In Thousands)

Calendar Year	Inpatient Hospital	Skilled Nursing Home	Physician & Medical Services
Aged Persons Served			
1967	3,601	354	6,415
1975	4,913	260	11,396
1980	5,951	248	15,627
1984	6,195	290	18,128
1985	5,714	304	19,590
1986	5,697	294	20,316
1987	5,752	283	21,496
Disabled Persons Served			
1974	397	8	691
1975	472	8	865
1980	721	9	1,631
1984	674	9	1,721
1985	636	10	1,820
1986	645	10	1,888
1987	642	10	1,986

SOURCE: Health Care Financing Administration, 1990.

FIGURE 3 — MEDICARE EXPENDITURES BY TYPE OF SERVICE.

MEDICARE PAYMENTS BY TYPE OF SERVICE
1975 And 1991



Source: Health Care Financing Adm., 1990

TABLE 7. — MEDICAID BENEFICIARIES SERVED BY TYPE OF SERVICE.

(In Thousands)

Persons Served

Calendar Year	General Hospital	Intermed. Care Facility	Skilled Nursing Facility	Physician Services
1972	2,832		552	12,282
1973	3,256	462	678	13,278
1974	3,291	627	661	14,970
1975	3,432	751	630	15,198
1976	3,551	813	637	15,624
1977	3,768	861	641	16,074
1978	3,782	844	639	15,668
1979	3,608	880	610	15,168
1980	3,680	910	606	13,765
1981	3,703	913	623	14,403
1982	3,530	914	559	13,894
1983	3,696	944	574	14,056
1984	3,467	937	559	14,195
1985	3,434	975	547	14,387
1986	3,544	973	571	14,894
1987	3,767	998	572	15,373
1988	3,832	1,011	579	15,265

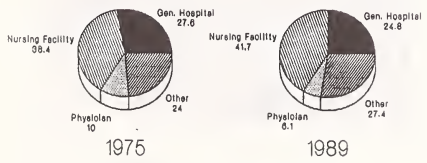
SOURCE: Health Care Financing Administration, 1990.

Looking at the distribution of the $49 billion spent on Medicaid in fiscal year 1988, 29 percent was for nursing home care, 28 percent for hospital inpatient, and 12 percent for Intermediate Care Facilities for the Mentally Retarded (see Figure 4). Thus, the greatest expenses were for nursing homes, even though this was not envisioned when Medicaid was originally passed.

Some selected utilization statistics provide further indication of the impact of Medicare and Medicaid. Figure 5 indicates that the percent of persons who had contact with a physician during a year increased between 1964 and 1988 from 70 percent to 86 percent for the elderly, and from 59 percent to 76 percent for those with family incomes below $10,000 per year. With respect to nursing home care, Figure 6 shows that the number of nursing home residents per population has increased dramatically since 1963. As shown by these statistics, there have been major increases since 1963 in the proportion of elderly and the poor who have received physician and nursing home care, presumably Medicare and Medicaid have played a major role.

FIGURE 4 — MEDICAID EXPENDITURES BY TYPE OF SERVICE.

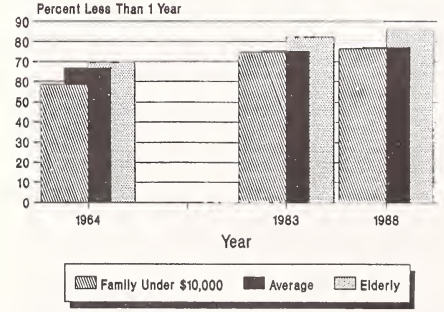
MEDICAID PAYMENTS BY TYPE OF SERVICE
1975 And 1989



Source: Health Care Financing Adm., 1990

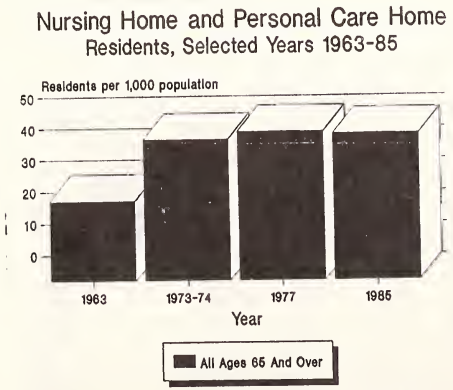
FIGURE 5 — INTERVAL SINCE LAST PHYSICIAN CONTACT.

Interval Since Last Physician Contact
1964, 1983 and 1988



Source: National Center for Health Statistics, 1990

FIGURE 6 — NURSING HOME RESIDENTS.



Source: National Center for Health Statistics, 1990

UNFINISHED AGENDA — GAPS AND WEAKNESSES IN MEDICARE AND MEDICAID.

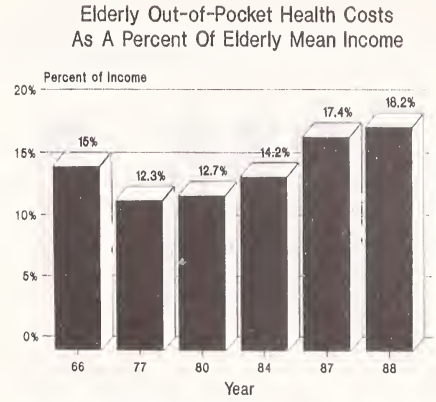
Despite the many accomplishments of these two programs, there still remain many gaps and weaknesses that need to be resolved. This section highlights a few key problems.

Rising health care costs. Health care costs have been rising at rates faster than the cost of living for at least the past two decades. This has created problems for the entire health care field, for employers and employees, for the Medicare and Medicaid programs, and for the elderly, the poor and disabled. For instance, while the Consumer Price Index increased by 23 percent from 1983 to 1989, medical care prices increased by 49 percent during this same time period.

One consequence of medical price inflation is pressure on the Medicare Hospital Trust Fund, now projected to be depleted between 1999 and 2018. The rapid increases for the Medicare and Medicaid programs are motivating policymakers at both the Federal and State levels to search for ways to constrain costs. This could result in the elimination of certain services or the elimination of certain groups from Medicaid. The same scenario is also occurring in the private sector, where employers are cutting back on health benefits.

For the elderly, another consequence of health care cost inflation is that health care costs are consuming an ever greater proportion of their income. Their out-of-pocket costs as a percent of income decreased from 15 percent in 1966 to 12.3 percent in 1977 and then increased to 18.2 percent in 1988 (see Figure 7). Thus, the out-of pocket proportion of income is 20 percent greater than when Medicare was first implemented in 1966 and 50 percent higher than in 1977. If present trends continue, the elderly will soon pay out-of-pocket costs representing more than one-fifth of their incomes.

FIGURE 7 — ELDERLY OUT-OF-POCKET COSTS.



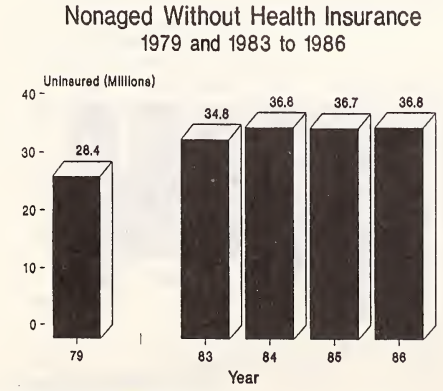
Source: House Committee on Aging, 1990

For the uninsured, the rise in health care costs has major consequences. Many of them are being denied access to even the most critical care. When they do receive such care, they experience staggering bills, which they are unable to pay or which consume a significant portion of their meager incomes. A majority of the uninsured have incomes that are less than 200 percent of the poverty line; yet their out-of-pocket costs of $430 per year are almost equal to those for the insured who on average have substantially higher incomes (US Bipartisan Commission, 1990). The situation is further exacerbated in that the number of uninsured has increased from 28 to 37 million persons between 1979 and 1986 according to the Census Bureau's Current Population Survey (see Figure 8).

Incomplete Quality Assurance. While quality of care has received considerable attention in the last few years, there remain many gaps in monitoring and assurance of high quality medical care. One of the reasons for concern is that there has been reports at Congressional hearings indicating that poor quality care has been delivered. There has also been research showing that, at least for selected surgical procedures, over 30 percent of the cases have been inappropriate (Rand Corporation).

To date there has been no definitive assessment of the quality of care provided by health care providers, largely because of the lack of a sufficiently acceptable set of quality measures. The field is only in the beginning stages in the development of outcome measures, which are the most fundamental in assessing the quality of care, and the initiation of effectiveness research which will test whether or not which medical procedures are more effective than others. Another significant gap is that quality assurance is fragmented between several parties including survey and certification agencies, the peer review organizations, and licensing bodies. There is very little in the way of communications between these entities. Finally, a major limitation is that quality assurance efforts focus on Medicare and, to some extent, on Medicaid, but do very little to protect the privately insured and the uninsured.

FIGURE 8 — UNINSURED.



Source: Current Population Survey, Census Bureau

Recently, several steps have been taken to improve this state of affairs. For instance, the Omnibus Budget Reconciliation Act of 1987 required the implementation of several quality assurance reforms, e.g. a consumer hotline, patient bill of rights, training of home health aides, new survey procedures. These procedures are soon to be implemented. Quality assurance for Health Maintenance Organizations is being beefed up, but is still in the early stages of development. Quality assurance for physician's offices is in the process of early implementation. However, even with these efforts, quality assurance has a long way to go before it fulfills its promise.

Coverage Gaps And Weaknesses. As a result of the repeal of the Medicare Catastrophic Care Act, the Medicare program still has major services uncovered such as extended hospital care, home health care, nursing home care, prescription drugs, and various preventive services. An even greater deficiency is the lack of a really meaningful long term care benefit, outside of Medicaid, for nursing home, home health, adult day care, and other forms of community based care including case management services. These are all critically important services for the elderly and the disabled.

Because States establish many of their own Medicaid policies as to eligibility, the Medicaid program covers only 42 percent of poor persons across all the different states as of 1986. With respect to the many elderly who need nursing home care, they are required to spend all of their assets before they are eligible for Medicaid. Furthermore, even with recent changes, States still vary in the amount of income and assets they will protect for the spouses of those persons needing such care.

As indicated earlier, States have substantial latitude on which services they cover under Medicaid. They may choose to include prescription drugs, eyeglasses, dental care and inpatient psychiatric care. Given this discretion, several states have chosen not to cover these services.

Provider participation. While there are a number of cases where physicians have not accepted Medicare beneficiaries as patients, acceptance of Medicaid patients by hospitals and physicians is a much greater problem. A 1977 study showed that for certain physician groups, i.e. psychiatrists, only 58 percent accepted Medicaid patients. For obstetricians/gynecologists, the number who accepted Medicaid patients was 64 percent. While a 1983 study showed that participation rates for most physician groups did not decline, the participation rate for obstetricians/gynecologists declined to 51 percent.

A recent GAO study on charity care also indicates that a number of hospitals may be providing less than their fair share of care to Medicaid patients. Many hospitals that provide a relatively small amount of charity care also serve a lower percentage of Medicaid patients than the other nonprofit hospitals.

Reimbursement. There have been expressions of concern that Medicare reimbursement levels do not adequately meet actual costs, or at least are less than that paid by private health insurers. However, even more substantial claims of inadequacy are made for the Medicaid program. For example, several studies have shown that Medicaid reimburses physicians at 70-75 percent of Medicare rates. Also, the Virginia Hospital Association, in a recent court suit, contends that Medicaid reimburses its hospitals at 71 percent of their actual costs.

Un- And Underinsured Health Care. Health insurance coverage for 250 million Americans of all ages is a deep and immediate concern to Congress because it is an essential element if people are to access needed health care and reduce the personal burden of catastrophic health costs. Every day, personal tragedies are hitting not only millions of individuals with catastrophic illnesses but their families as well. Studies continue to document serious gaps in health insurance coverage. As noted earlier, as many as 37 million persons -- over 14 percent of Americans -- are uninsured.

Of equal concern are the many millions who are underinsured -- those whose existing health insurance coverage is inadequate. Millions of Americans are underinsured when it comes to catastrophic health care costs. For the uninsured and underinsured, the risk is great and growing. One million families have at least one family member who was refused care because of inadequate funds. Up to 10 percent of families face health costs in excess of 10 percent of their incomes.

Un- And Underinsured Long Term Care. When facing a catastrophic long term illness, over 200 million Americans are underinsured, except for the potential protection of Medicaid. A very small percentage of the U.S. population has private long term care insurance. A study by the Brookings Institution shows that the number of people with private long term care insurance will grow, but also clearly shows that a substantial portion of the elderly and many nonelderly are unlikely to ever have private long term care insurance. For all practical purposes, Medicare does not cover long term care. While Medicaid does provide coverage to many persons, it is only after the person needing long term care is impoverished and their spouse has exhausted a substantial portion of his or her income and assets.

A 1987 study by the House Select Committee on Aging showed that over four-fifths of single elderly and over one-half of elderly couples are at risk of spending their incomes down to the poverty level after an elderly person is in a nursing home for six months. While the new Medicaid spousal protection provides some help to the spouse remaining in the community, the nursing home resident is vulnerable to the indignity of having to spend down to poverty. Without long term care protection, the result is that families can face a double catastrophe. The first catastrophe is being hit with the heavy emotional burden of caring for a family member with a long-term disabling illness. The second catastrophe is the huge financial burden and, possibly, the indignity of spending down into poverty or the Medicaid program.

FUTURE OF FEDERAL ROLE IN HEALTH AND LONG TERM CARE

To solve the various gaps and weaknesses in the Medicare and Medicaid programs, two sets of solutions have been proposed. One set is to eliminate as many gaps in these programs as possible. The second is to develop more comprehensive solutions that address the entire health care system and that go beyond just Medicare and Medicaid. This section will highlight several of the key proposals that address many of the above limitations. Time does not permit discussion of all the proposals that deal with each of the above limitations even though all of them need to be addressed. The discussion will first cover changes to Medicare and Medicaid.

Strengthening Medicare And Medicaid. There are many changes to Medicare and Medicaid that have been considered. For Medicare, discussions have included revisiting the provisions of the Catastrophic Care Act that were repealed. As indicated earlier, these could include adding back catastrophic hospital coverage, and the nursing home, home health, and prescription drug benefits.

Additional proposals primarily address the need for a comprehensive long term care benefit for the frail elderly and other persons with disabilities. Estimates are that by the year 2030 about 4 million persons will reside in nursing homes and 12 million disabled elderly will live in the community with needs for daily assistance. For these persons, long term care benefits are needed that include more extensive nursing home, home heath, and other community based care services. All of these services could just be added to the Medicare program or they could be added to the Medicaid program.

The long-term care expansions of Medicaid could take the form of either additions in services to the basic program or in the form of a long term care block grant program that involves combining funds from several different Federal programs into one pool to be administered by the States. One way of making additions to Medicaid is to change the Home and Community Based Waiver Program so that waivers are no longer required and that States could simply add this benefit at their option for the frail elderly. Another proposed change is to increase the housing allowance, or further increase the income and assets protected for either an institutionalized individual and/or their spouse.

Other changes that have been proposed for Medicaid include establishing uniform eligibility standards across all states that ensure that all persons below the poverty line are covered and possibly go to higher thresholds such as 185 percent of the poverty line for high priority groups. Another approach is that Congress could require all states to cover the medically needy. Other approaches address some of the weaknesses discussed above, including increases in reimbursement levels to providers. Finally, proposals have been offered to provide ways for the uninsured and underinsured to be covered through Medicaid. Various methods could be used to include these groups, such as payment from State or Federal revenue sources, by employers, or by the individuals.

Comprehensive Health and Long Term Care Reform. As was the case in the late 1970s, a number of proposals for comprehensive health care reform have emerged. This section will review several major proposals that represent a range of different approaches, including proposals offered by coalition groups.

One proposal, recently made by the US Bipartisan Commission (otherwise known as the Pepper Commission) represents an approach of requiring employers to ensure coverage for their employees and of extending Medicare and a revised version of Medicaid. Their recommendations included the following:

Universal Health Care Coverage:

- Businesses with more than 100 employees would provide private health insurance or contribute to a public plan for all employees and non-working dependents.
- Businesses with 100 or fewer employees would be encouraged to provide health insurance for employees and non-working dependents. Tax credits for some small employers would be available.
- The federally operated public plan would cover employees and dependents that contribute and non-working individuals who buy in or are subsidized. The plan would replace Medicaid for the specified services and would pay providers according to Medicare rules.
- The minimum benefit package would include primary and preventive care, physician and hospital care and other services. Services are subject to cost-sharing, with subsidies for low-income people and limits on out-of-pocket spending.

Long-Term Care:

- The Commission plan would establish a Nursing Home Program that would provide financial protection and ensure that no one faces impoverishment.
- Nursing home patients would be entitled to social insurance for the first three months of nursing home care. Such front end insurance would allow people who have short stays to return home with resources intact.
- Severely disabled persons would be eligible for social insurance for home and community-based care.
- The Federal government would finance the home and community-based care program and the front end nursing home care. The Federal and State governments would share in financing the Nursing Home Program.
- Private long-term care insurance, subject to government oversight, would fill gaps not covered by the plan.

There are several other comprehensive proposals that have been discussed and take somewhat similar approaches to the Pepper Commission. The Basic Health Benefits for All Americans Act proposes a pluralistic health care system with a public-private partnership to assure care. Employers are required to cover their employees and Medicaid programs are expanded to cover the poor and near poor. The Act requires all working Americans and their dependents, as well as the uninsured to have basic health insurance. For Americans who are not covered by Medicare and unable to participate in employment based insurance, the legislation establishes a phased-in public Federal/State program to provide subsidized insurance coverage. The required benefits package must include most acute care, some preventive care and catastrophic coverage limiting out-of-pocket costs for covered services to $3,000 per family. This proposal does not include a long-term care benefit package.

Another acute care oriented proposal is The National Leadership Commission on Health Care Proposal. The proposal retains the Medicare program and private insurance. The Federal government would provide guidelines for a new Universal Access program which would not be centrally directed as is the Medicare program. The proposal requires all Americans to have basic health insurance, whether obtained privately, publicly or by employer benefit plans. Older Americans would continue to receive Medicare coverage. The National Leadership Commission does not consider it appropriate for it to establish the original national basic benefits package for all Americans. However, the Commission recommends that mental health benefits and preventive services, especially prenatal care, be included in this package. As with the previous plan, the Commission did not specifically address long-term care.

Another variation is The Health Security Partnership Plan which retains the Medicare program with the remaining people being covered by a State system based within Federal guidelines. Private insurance would be continued in modified form, and may serve as qualified insurance delivery plans to be selected by employees and those not with an employer through which they may receive benefits. Medicare continues with its payment practices and standards integrated in the Health Security Partnership over time. The plan provides universal coverage for all U.S. residents. The Medicaid program would be folded into the public program. The basic benefits package to which all eligible individuals are entitled is comprehensive in nature. A beginning long-term care program which provides added benefits for those past the age of 65 and the disabled is to be inaugurated in the first phase. In the second and third phases, eligibility is to be extended to those under the age of one, and then to the rest of the population.

Though not a separate proposal, the Canadian National Medicare Model has been given much consideration. Canada's plan is administered by ten Provincial governments which operate within the Canadian Federal government's guidelines. It provides universal access to all legal residents of a province after a short waiting period. Comprehensive coverage includes all medically required services rendered by medical practitioners in hospitals, clinics or doctor's offices. Inpatient and outpatient hospital care, prescription drugs, diagnostic and lab tests, mental health care as well as preventive care including pre-natal and well-baby care are also covered. Limited dental care is available in some provinces. In contrast to Canada's well-established acute health care system, the financing and delivery of long-term care are in a state of change, with some coverage, but significant variation among the provinces.

Finally, a federally-oriented approach has been offered by Congressman Roybal, Chairman of the House Aging Committee, under the title of the USHealth Program Act (H.R. 2980). It establishes a Federal program based on Medicare and managed by the USHealth Administration, the current Health Care Financing Administration. USHealth replaces Medicare, Medicaid and private insurance plans and is set up as an independent agency and. Most bill processing and review is to be provided through contracts with private insurance companies. Within the USHealth Program Act, financial access is ensured by making every citizen and permanent resident eligible. The basic health and long term care benefits include those covered by Medicare, dental services, prescription drugs, preventive services and long term care (care management services, home and community-based care, nursing home care). Total expenditures under USHealth are capped at 12 percent of the Gross National Product.

CONCLUSION.

Though the rich history of Medicare and Medicaid is replete with lessons for the future, the question remains as to whether or not this nation will take the time and has the wisdom to learn those lessons. Twenty-five years ago on July 30, 1985, a President and a Congress took the bold and courageous action to enact a protection package for millions of elderly, poor and disabled. No one then thought Medicare and Medicaid were the perfect solutions, but few doubted that many people's lives would be much better as a result of that bold action. Today, few dispute that millions of Americans are better off due to Medicare and Medicaid.

Looking to the future, the nation has two responsibilities. The first responsibility is one of stewardship over Medicare and Medicaid as they are today. Just maintaining the health and well-being of these two programs will be no minor task for the Administration and Congress. It is a task that will be made more difficult to the extent that it is done in an adversarial environment. Most Americans agree that Medicare and Medicaid are too important to be allowed to fall victim to partisanship and expect their national leaders to fulfill their stewardship responsibilities.

The second responsibility is to those who have yet to benefit from this nation's greatest step forward toward protecting the health of its citizens. When millions live at risk and in fear of a long term disabling illness wiping out the financial and emotional resources of their families, a nation cannot be satisfied with Medicaid as the nation's long term care policy. When millions are forced to seek charity for whatever health care they need, a nation can feel no pride in having the best medical care in the world.

In a world which has increasing doubts over the United States' ability to step forward and show leadership on the great issues of the day, health and long term care protection is one case where this nation not only fails to lead but fails to keep up. Twenty-five years would seem to have been more than enough time for this nation to take its rightful place of leadership; thirty years is too long.

APPENDIX II

JAIME B. FUSTER
PUERTO RICO

WASHINGTON OFFICE:
427 CANNON BUILDING
WASHINGTON, DC 20515
(202) 226-2615

DISTRICT OFFICE:
P.O. BOX 4751
OLD SAN JUAN, PR 00902
(809) 723-6333

Congress of the United States
House of Representatives
Washington, DC 20515

COMMITTEES:
FOREIGN AFFAIRS
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INTERIOR AND INSULAR AFFAIRS
SUBCOMMITTEES:
INSULAR AND INTERNATIONAL AFFAIRS
NATIONAL PARKS AND
PUBLIC LANDS

EDUCATION AND LABOR
SUBCOMMITTEE:
EMPLOYMENT OPPORTUNITIES

July 30, 1990

Hon. Edward R. Roybal
Chairman
Select Committee on Aging
A712 HOB Annex 1
Washington, D.C. 20215-6361

Dear Mr. Chairman:

I appreciate your holding hearings to discuss and review the accomplishments and shortcomings of the Medicaid and Medicare programs on the occasion of their 25th anniversary and take this opportunity to express my views on these two programs. I also request that these comments be made part of the hearing record.

The situation and present condition of Puerto Rico's health care system is extremely precarious and the health care needs of our predominantly poor population very pressing. At 13.7% per 1,000 births, Puerto Rico's mortality is one of the highest in the nation. Childhood diseases like chicken pox and measles, usually easily controlled, still run rampant. Life expectancy at birth declined in Puerto Rico between 1981 and 1986.

The Medicaid program is presently available in Puerto Rico, but under different rules than in the other 50 states. In Puerto Rico, Medicaid funding is arbitrarily capped. Moreover, the Federal matching funds to Puerto Rico have been unrealistically low vis-a-vis the 50 states. According to figures provided to me by the Puerto Rico Hospital Association, between 1968 and 1989, Federal matching funds to the island experienced a 281% change, while the average Federal Medicaid payment experienced a 1636% change.

The bare facts speak for themselves. According to the Medicaid Source Book of 1988, Mississippi, the poorest state in the nation, which has a per capita income two times that of Puerto Rico, has 318,871 Medicaid beneficiaries compared to 1,761,833 in Puerto Rico. Under the present formula, the total Medicaid payment to Mississippi is $348.6 million compared to $146.6 million for Puerto Rico. The Medicaid payment per beneficiary in Mississippi is estimated at $816 while in Puerto Rico it is $86.

Puerto Rico receives equally inequitable treatment under Part A (Hospital Services) of the Medicare program. Since 1984, most Medicare inpatient hospital services in the United States have been reimbursed under the "prospective payment system", or PPS. Hospitals in Puerto Rico became subject to the rules governing PPS in October of 1987. However, the general formula for the calculation of prospective payment rates for hospitals located in Puerto Rico differs substantially from the formula used on the mainland. Puerto Rico's PPS rates are substantially lower than those prevailing on the mainland even though many of the hospital costs in the island are more expensive than those on the mainland.

At current funding levels Puerto Rico is unable to adequately meet the health needs of our large and disadvantaged population. Puerto Rico is presently overburdened by trying to meet its health expenditure requirements and keep up with inflation and population growth. For instance, government spending on health care per capita has only risen $2.82 in 18 years, $42.58 in 1972 as compared to $45.40 in 1990.

The health of our people, the condition of our hospitals and the quality of our health care system will continue to deteriorate to critical levels until the lack of adequate and sufficient Federal funding for Medicaid and Medicare programs is addressed. Because the health of human beings is at stake, time is of the essence.

Moreover, the pandemic spread of the AIDS epidemic in Puerto Rico underscores the urgency of maintaining and improving current levels of health care. It is estimated that approximately 5 percent of public hospitals in the United States treat 50 percent of all people with AIDS. Only 13 cities in the U.S. bear the burden of more than 55 percent of the total AIDS cases. San Juan, the capital of Puerto Rico, is one of those unfortunate 13 cities.

Although present AIDS legislation directs much needed funds to assist Puerto Rico to deliver services to its AIDS victims, the assistance is only short term. Resolving the ongoing inequities in the Medicaid and Medicare programs is the only answer to addressing the problem of AIDS and all other long-term health care needs of Puerto Rico.

For the compelling reasons stated above, I urge you to address this inequity that Puerto Ricans must endure and which grossly disregards the real needs of the 3.3 million U.S. citizens in Puerto Rico.

Once again, I commend you for holding this hearing and stand ready to work with you and your staff to find suitable solutions to a real problem.

Cordially,

Jaime B. Fuster

Jaime B. Fuster
Member of Congress

FOR THE RECORD

TESTIMONY OF

BRUCE BROWN

My name is Bruce Brown. I live in Arnold, MD. I am pleased to share this information about me and my family and hope that it may help others.

My mother-in-law is Elsie Ernst. She is 82 years old and lives in Baltimore. She is legally blind in one eye and has tunnel vision in her second eye. Two years ago she tripped while walking in the street and fell flat on her face. That incident brought on what the doctor calls "organic brain syndrome with senile dementia." My mother-in-law suffers with hallucinations as well as very limited vision.

My sister-in-law Shirley Ernst and her mother live together in Baltimore. Shirley has been employed as a secretary by Mercy Medical Center in Baltimore for 26 years. She continues to work on a full time basis. In addition, she is responsible for all of my mother-in-law's needs. She does all of the meal preparation, laundry, cleaning, shopping, etc.

My mother-in-law's income is $425 from Social Security and a pension of $127. She had been a very independent woman and had worked many years ago in an insurance agency.

Our family cannot afford to pay for help in the home or for day care which is $50 a day plus transportation. We prefer to have her at home, but don't know how we would pay for a nursing home even if that were to become necessary. Therefore, my mother-in-law is left alone on a daily basis. Shirley says, "I put her in the Lord's hands when I come to work. What can I do." As it is, Shirley says her mother calls "92 times a day" and sometimes it's hard to get her own work done.

Shirley doesn't even think about taking a vacation because no one else in the family can take over for her. Shirley's only recreation is one night a week participating in the church Hand Bell choir. Whenever Shirley is out of the house, she and her mother are in constant touch by phone. Shirley is convinced that one day the "intruders" in the home that her mother talks about and fears may be real and Shirley will not know until it's too late. In addition to her emotional support and all of the physical work that Shirley does for her mother, she also supplements her mother's income and pays for many of the expenses in the home.

My wife, Jane, and I wish we could help Shirley and her mother move, but we have our own problems. I have had End stage Renal Disease for five years and am on Social Security disability. I was working in 1985 as a salesman for a moving company, but lost my job when I started on kidney dialysis. I applied for disability when I became unemployed and was told that I had to wait six months before I would get a check. Although my wife was working full time at Mercy Hospital, with our obligations, we could not make it on her salary alone, and I had to file bankruptcy. My wife has continued to work full time, but we are only beginning to recover from the bankruptcy.

At the same time, I have been plagued with medical problems. I had coronary by-pass surgery in 1989. I have vascular disease and have had several toes amputated. I also have gastro-intestinal bleeding. Because of these conditions, I have had to spend a great deal of time in the hospital. I had hoped to have a kidney transplant, but this is now out the question because of my continuing congestive heart failure and vascular disease.

Because of the demand that my illness makes on my wife and family, she is not able to help her mother and sister either financially or with actual care as much as she would like.

My wife and I have three sons. Brian (23) and Jeffrey (15) still live at home. Kevin (21) has recently moved into an apartment in Washington. All of my children work. The older two are waiters and health insurance is not included in their employment. Only my youngest son is covered by my wife's health insurance. The older boys could be covered by my wife's insurance if they were categorized as students. However, since we cannot afford to send them to college, they have had to work and pay their own way. Since they do not meet the minimum required hours for student status which would include them in the family policy, for each of them as working children would be $169.00 per month. Neither of them can afford this and therefore they have no health insurance. As a matter of fact, in 1989 and 1990, Kevin had to have surgical procedures. He currently owes the surgeon $600, the anesthesiologist $400 and the hospital $2000. He pays monthly payments toward each of these obligations. In addition, he has a student loan to be paid.

I feel very fortunate to have Medicare as well as some insurance through my wife's work. Without both of them my family and I would be "busted." However, I wish there were more assistance available for people like my mother-in-law and my kids.

KIMBERLY QUALITY CARE®

Quality of Life is Our Commitment

TESTIMONY

ON THE 25TH ANNIVERSARY OF MEDICARE/MEDICAID

BY

KIMBERLY QUALITY CARE

Presented before the

Select Committee on Aging

U.S. House of Representatives

JULY 31, 1990

Kimberly Quality Care
A Division of Lifetime Corporation
695 Atlantic Avenue, Boston, MA 02111
(617) 951-2700 (800) 533-9735 FAX (617) 951-2789

TESTIMONY

ON THE 25TH ANNIVERSARY OF MEDICARE/MEDICAID

JULY 31, 1990

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Thank you, Mr. Chairman, for giving me the opportunity to testify on the occasion of the 25th anniversary of the creation of Medicare. I am Sunny Sutton, Senior Vice President of Medicare Services for Kimberly Quality Care, which is the nation's largest health care and personnel services company. We are strongly committed to providing cost effective and quality services to Medicare and Medicaid beneficiaries. Today, as we commemorate the 25th anniversary of the creation of Medicare, the health care industry and the Federal government must work together and learn from the successes and failures of the program so we can chart our course for the future.

In 1936, President Franklin D. Roosevelt signed into law the Social Security Act which Congress enacted to ensure a better quality of life for all Americans. Social Security gave us a sense that our retirement years would be free from worry and the means by which we could age with dignity and decency.

Social Security helped but did not solve all of our problems. It

became obvious that regular Social Security pension checks would not be enough to cover needed medical care, and people had to start exhausting all of their personal savings. The world was getting much too complicated to rely on simplistic solutions to our problems.

In 1965, Congress acted again to help older Americans who were then spending more than 20 percent of their income for treatment and medicine. After a heated, hard-fought battle in Congress, President Lyndon B. Johnson signed into law the Medicare and Medicaid programs, amending and enlarging the scope of the Social Security Act of 1936. Medicare, as well as Medicaid, were created in the hope that we could not only age with dignity, but that the medically disadvantaged and the disabled would be taken care of as well.

Now, 25 years later, health care costs continue to escalate. More than 11 percent of our gross national product goes toward paying for health care in this country. As our population grows older and lives longer, there will be more older adults than ever before who will need care. We have to plan now to take care of this problem before it grows worse. Congress must continue to act responsibly to ensure that Medicare is adequately funded and that such funds can help deliver quality care.

On the positive side, however, health care has become more innovative through technological and medical advances and

provides more alternatives than ever before. Hospitals and nursing homes were once the only options, and patients and families were reluctant about the cost and burden of lengthy stays. Now, with alternatives to the institutional setting, who can be reluctant about long term care when it is provided at home? Undoubtedly, Medicare has played an important role in providing the home care services Americas need.

Many situations force families to make difficult health care decisions: What to do when an accident results in a partial disability; what to do when an aging parent no longer can handle the activities of daily living; what to do when a spouse suffers a stroke; and what to do when advancing emphysema requires respiratory therapy. The only option known to many families is a lengthy and costly stay in a hospital or nursing home. There are other alternatives. Today, we know that people tend to heal better and faster at home -- that home most often is a happier and far less dispultive environment for all concerned.

Home care, in most cases, is the most effective cost alternative, and Medicare is an important component to providing those services. Our caregivers develop comfortable, yet professional relationships in the home and are supportive to clients and family members. We are sensitive to the value of a warm, human touch in the home. We foster compassion and understanding, as well as professional competence, in all our personnel.

Many agencies in the home care industry are Medicare certified and administer the program so as to maximize the benefits that those who are eligible derive from the program. Kimberly Quality Care, as well as other agencies, have specialists in all certified offices and are knowledgeable on current Medicare guidelines and benefits. They help determine the Medicare eligibility and coverage of each individual client. We educate clients and their families as to choices and options and work to find reimbursement alternatives for clients whose needs are not met by Medicare.

The concept of Medicare is a good one. It must be kept viable if Americans are to have the kind of security they need. Home care, respite care, hospice, infusion therapy all are types of care that we cannot afford to ignore, and Medicare plays and important role in insuring that these services are covered.

In playing an important role, Medicare must continue to make available to beneficiaries health care services that have become more sophistocated due to advances made in high-tech home care therapy. Without high quality technology, home care for Medicare beneficiaries and others would not be possible. Thanks to some of the infusion therapies, such as antibiotic therapy, Medicare beneficiaries can help take care of themselves at home with little assistance. Other more complex home care technologies, such as home ventilators, require skilled assistance. Only a few years ago did health care professional begin to imagine the many

possibilities associated with high-tech care and how it would come to involve the home care setting without the disruption to family life.

Medicare has helped alleviate the pain and suffering of many patients and families by allowing these services at home. In closing, the home health care industry appreciates the support from Congress and its recognition that home health care plays a major role in providing high quality health care for many Americans. Thanks to Medicare, we have been able to reach out to people and provide them with cost effective and compassionate home care services because we cannot afford to compromise with the quality of life. Quality of life is our commitment as a company, and it must be our commitment as a nation. Thank you, Mr. Chairman and members of this Committee, for allowing us to present this testimony.